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A Description of the Socio-cultural Context of Sexual Health in Ulaanbaatar, Mongolia
for a School-based Peer Education Program

by

Amanda Bridget Roberts



A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment
of the requirement for the degree of Master of Science

in

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled A Description of the Sociocultural Context of Sexual Health in Ulaanbaatar, Mongolia for a School-based Peer Education Program submitted by Amanda Bridget Roberts in partial fulfillment of the requirements for the degree of Masters of Science in Medical Sciences in Public Health Sciences.



ABSTRACT

Although one does not exist now, many conditions indicate that Mongolia is vulnerable to an HIV epidemic. There are distinct knowledge gaps regarding sexual health among Mongolia's population; half of which are under the age of twenty.

With the intention of implementing a school-based peer education program, this study conducted focus groups with health staff, teachers, and students to assess the appropriateness of peer education in Mongolia, the external environment, and program design. The findings provided a description of the socio-cultural context of sexual health among youth in Ulaanbaatar, Mongolia. Reciprocal determinism was used to illustrate the interaction of socio-cultural factors with structural, individual, and behavioural factors and explain the similarities and differences between Mongolia and other countries. Peer education is an appropriate intervention and the potential program directions and limitations are highlighted. Finally, recommendations were generated about the development of the peer educator, program design, and multi-level support.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
GTZ	<i>Deutsche Gesellschaft Fuer Technische Zusammenarbeit</i>
HIV	Human Immunodeficiency Virus
IEC	Information, Education, Communication
IUD	Intrauterine Device
MNT	Mongolian Tugrik
MOHSW	Ministry of Health and Social Welfare
MPRP	Mongolian Peoples Revolutionary Party
MSF	<i>Medicins san Frontier</i>
NAF	National AIDS Foundation
NGO	Non-Government Organization
NSO	National Statistics Office, Mongolia
SAPS	Structural Adjustment Programs
SIECUS	Sexual Information & Education Council of the United States
STD	Sexually Transmitted Disease
UN	United Nations
UNFPA	United Nations Population Fund

CHAPTER 1

Introduction

Mongolia is a landlocked country in central Asia, situated between the Russian Federation and the People's Republic of China. Since 1990, the winds of change have been sweeping Mongolia, starting with the collapse of the Soviet Union and its subsequent withdrawal of significant political and economic support. It is a country in political, economic, and cultural transition. In ten years, this developing country has gone from a socialist government to a democratic government and has progressively been moving from a command economy to a market economy. Incredible inflation rates and a depressed economy have increased the incidence of internal migration, poverty, and prostitution. Reform has also impacted health care in Mongolia; it has been slowly privatized and a shift from a strong curative orientation to a focus on primary health care has been encouraged. In addition, once a very isolated country, Mongolia has since been exposed to new cultures and media. Lessons from HIV/AIDS epidemics in other locales indicate that all of these changes and instabilities favour an HIV epidemic.

At the end of 2000, 36.1 million men, women and children were living with HIV or AIDS and 21.8 million had already died from the disease (UNAIDS, 2000a). In 2000 alone, there were 5.3 million new infections worldwide (UNAIDS, 2000a). Approximately 500,000 people were living with HIV/AIDS in China at the end of 1999. During that same year, 130,000 people from the Russian Federation were living with HIV/AIDS (UNAIDS, 2000b). To date, only two people have been reported to be infected with HIV in Mongolia (Patel & Amarsanaa, 2000). Young people are particularly vulnerable to HIV as it is estimated that half of all HIV infections occur among young people under the age of 25 (Rivers & Aggleton, 1999).

Mongolia has a very young population with almost half of its citizens under the age of 20 (Patel & Amarsanaa, 2000). The incidence of sexually transmitted diseases (STDS) have increased dramatically between 1992 and 1997, confirming that the conditions that favour the rapid spread of HIV are present (Reilley, Narantuya, & Oyungerel, 1999). In response, the Ministry of Health and Social Welfare (MOHSW) is shifting the system towards primary health care with reproductive health as its top

priority. A survey conducted by Reilley et al. (1999) extensively assessed sexual knowledge, attitudes, and behaviours of youth in Mongolia and found that knowledge gaps exist regarding HIV/AIDS, STDs, and contraception. In addition, the use of modern contraception was very low. This survey was followed by focus groups to further understand the attitudes and motives that drive these behaviours. The focus groups found that sex is a taboo topic and that accessing sexual health information can be very stigmatizing (Oyungerel et al., 1999). At this point awareness is a critical problem.

What has been learned from around the world is that there are many factors that contribute to the HIV/AIDS epidemic. These factors are also determinates of sexual health and Parker, Easton, & Klein (2000) broadly categorizes them into three layers: structural, socio-cultural, and individual determinants. Although many health promoting interventions, including peer education, have focused on the individual factors such as knowledge, attitudes, and behaviour (MacPhail & Campbell, 1999), proper assessment and consideration of the structural factors (e.g., economic development, political environments, and gender inequalities), and socio-cultural factors (e.g., gender roles, traditional values, social norms) are needed to significantly reduce HIV transmission.

Social learning theory is used in the present study to understand how these layers of determinants interact to affect sexual health. It suggests that human behaviour is determined through the continuous interaction between cognitive, behavioural, and environmental (i.e., structural and socio-cultural) factors in the belief that people and their environment are reciprocal determinants of each other (Bandura, 1977). Furthermore, social learning theory provides an explanation as to how people learn within social contexts, postulating that learning is based on role modelling and reinforcement of behaviour (Bandura, 1977). These are the background principles of peer education.

Peer education is essentially a method of delivering information, norms, and skills to a target audience by using the naturally occurring process of peer networks that people learn from everyday (Shiner, 1999). Peer education is an attractive means of sexual health information delivery because reinforcement is frequently made among peer groups who have more social contact and the peer role models are perceived to be more credible than other sexual health information sources such as teachers. As a health promoting intervention, peer education can be cost-effective, credible, make positive changes on

social contexts, and provide benefit to the educators themselves. Peer education programs focusing on sexual health have been successful in many countries and among many different social groups. Peer education programs have been very successful among young people in China, Denmark, Myanmar, and Guyana to name a few (UNAIDS, no date). Surveys have demonstrated that good quality sexual health peer education programs have helped delay first intercourse and promoted responsible and safe sexual behaviours (UNAIDS, 1997). Sexual health peer education programs have been introduced to sex workers and college students in Mongolia (Reilley et al., 1999).

Peer education may also be an appropriate intervention to address the knowledge gaps and skills that exist among Mongolia's young people. The present study served to explore the socio-cultural context of sexual health with the intention of implementing a school-based peer-led sexual health education program for youth in Ulaanbaatar, Mongolia. Focus group discussions with health staff, teachers and students were used to explore and describe the socio-cultural context of sexual health in Mongolia and thereby assess if a peer-led sexual education program is an appropriate intervention for young people. The focus groups were also used to determine a peer education program design and development of the peer educators themselves.

CHAPTER 2

A Description of Mongolia

Country Description

Mongolia is a landlocked country in central Asia, situated between the Russian Federation and the People's Republic of China. It is one of the most sparsely populated countries in the world with 2,650,952 people living in 1.5 million square kilometres of desert, steppe, and mountains. Mongolia is very young country with 46.5% of the population under the age of 20. The life expectancy for men is 61.1 years compared to women's 67.7 years (Patel & Amarsanaa, 2000).

Mongolia's primary ethnic group is Khalkh Mongol (86%) and speak the language of the same name. Seven per cent of the population are Khazakh, living in western Mongolia and speak Khazakh (Patel & Amarsanaa, 2000). Russian used to be the most common second language, but every year, more and more people are learning English (National Statistics Office [NSO], UNFPA, MOHSW, & UNSD, 1999). Since its Soviet liberalization, Mongolia has experienced a major revival of Buddhism, their primary religion, although the Khazakh population is Islamic (Patel & Amarsanaa, 2000).

People are migrating to urban centres to meet the increasing demand of industrialization, with 51% of Mongolians currently living in urban settings (NSO et al., 1999). Twenty per cent (21%) of the population lives the traditional nomadic lifestyle (Government of Mongolia & UN, 1999). Most Mongolians live in their traditional, mobile home called the *ger*, however, half of urban dwellers live in apartments (national statistics). Only 23% of Mongolian homes have running water but the majority (67.7%) have electricity (NSO et al., 1999).

Mongolia has a very rich history, perhaps remembered best for the great Mongolian Empire founded by Chinngis Khan in 1189 (Greenway, Storey, & Lafitte, 1997). This empire played a major role in world affairs between 12th and 14th centuries as the empire stretched across Asia, from Turkey to the Pacific coast of China. To this day, Chinngis Khan is a national hero and icon, with his face and name on money, restaurants, and vodka bottles (Greenway et al., 1997). Internal strife lead to the collapse of the empire and Mongolia became part of Manchu in 1691. The Qing Dynasty ruled Mongolia

for almost 200 years until 1911 when Mongolia was declared an autonomous country (NSO et al., 1999). The Manchurians tried to claim the country for its own again in 1919 but the Soviet People's Republic came to the aid of the Mongolians. In 1924, Mongolia became a socialist government with the Mongolian Peoples Revolutionary Party (MPRP) in power. The MPRP ruled as a one party socialist state until 1992 with the significant backing of the Soviet Union (Patel & Amarsanaa, 2000).

Democratic changes began to occur in 1990 with the collapse of the Soviet Union. A democratic constitution was adopted in 1992 and Mongolia's first multi-party elections were held. The MPRP won that first election and a democratic coalition won the 1996 election. In the June 2000 election, Mongolians once again voted the MPRP into power. These rapid political changes have been coupled with their economic ideals, changing from a centrally planned economy towards an open market economy at a time when the country was trying to recover from a lack of Soviet resources.

The Mongolian economy has been volatile since the withdrawal of the Soviet Union and its financial aid. It estimated that the Soviet Union subsidized 40 to 65% of the national health budget (Government of Mongolia & UN, 1999). In 1996, the total government expenditure on health was 52% of 1990 expenditures (Government of Mongolia & UN, 1999). In 1998, the government spent 3.3% of the Mongolia's gross domestic product (GDP) on health care (Patel & Amarsanaa, 2000). Major economic and structural adjustments such as decentralization have occurred in the last decade, having a major negative impact on employment and social welfare (Patel & Amarsanaa, 2000). Inflation has been high but is stabilizing. In 1990, a loaf of bread cost 1 Mongolian Tugrik (MNT); in 2000 a loaf of bread cost 250 MNT (personal notes). The annual inflation rate has decreased from 44.6% in 1996 to 10.0% in 1999 (Patel & Amarsanaa, 2000). Increased unemployment and financial strain has given way to more alcoholism, violence, and abuse among Mongolian families (UNICEF, 1999). A very prominent example of this is the nearly 1,000 street kids living in the capital city of Ulaanbaatar. In addition, lack of employment has led to an increase in commercial sex workers (Government of Mongolia & UN, 1999).

Cultural changes are sweeping the country as Mongolia's doors open to the world to mass media. The most common source of information is the radio with almost 84% of

urban residents and 73% of rural residents tuning in, while 96% of urban residents watch television (NSO et al., 1999). These mediums are exposing Mongolian youth to Western culture through pop music, television, and movies (Reilley et al., 1999).

Sexual Health in Mongolia

Before 1990, health care in Mongolia was highly centralized, specialist¹, curative orientated, and free. Changes to health policy and planning were needed to accommodate drastic reductions in health funding and to meet shifting demographic and epidemiological profiles. As a result, two major changes within the health sector have been made. The first was the decentralization of budgetary responsibility to *aimag* (provincial) and *soum* (district level) authorities in 1993. Rapid decentralization has presented many limitations as the health sector staff lack knowledge and experience with budgetary processes and the situation remains in a capacity building stage at present (Government of Mongolia & UN, 1999). Second, with the introduction of health insurance for the working population in 1994, the government dropped free health services. Health facilities were also allowed to charge user fees. It is the government's goal that insurance and private payments will absorb 60% of the health budget by 2002 (Health Sector Review).

Between the 1920's and 1990's, Mongolia has pursued pro-natalist policies to build the sparsely populated nation (Patel & Amarsanaa, 2000). Most of the policies included financial incentives to mothers and families that have large families, some of which remain today. For example, women who raise four or more children qualify for old age pension at age 50, five years earlier than other women (Patel & Amarsanaa, 2000). Another example is the 'First Degree Order of Mother's Honour' where a large cash reward has been presented by the president annually since 1957 given to women who rear eight or more children (Patel & Amarsanaa, 2000).

Today, Mongolian women marry at the median age of 20. On average, they are 21.6 years old when they give birth to their first child and will have three children (UNFPA). In a 1998 survey, the mean ideal number of children reported by married

¹ Most physicians in Mongolia are trained in a specialty; there were not any general practitioners in practice in Mongolia until very recently.

women was found to be 3.5. However, most women wanted either 2 or 4 children, varying by urban or rural residency respectively (NSO et al., 1997). Urban women had 2.4 children at the time of her last unwanted pregnancy and rural women had 3.1 children (Patel & Amarsanaa, 2000).

Contraception has historically been discouraged because of these pro-natalist policies. At limited selection of contraceptive devices (e.g., intrauterine devices (IUD) and condoms) became available in Mongolia in 1976, however, it was not until the 1990s that additional contraceptives were made available in 1990s by UNFPA including the contraceptive pill, Norplant, and injectible contraceptives. The IUD is the most popular modern contraceptive available as 93% of women are aware of it and 23% of women are currently using it (NSO et al., 1999; Patel & Amarsanaa, 2000). The utilization of other modern contraceptives is low; the pill, condoms, and injectible contraceptives were currently used by 3%, 2.8%, and 2.3% respectively of women surveyed (Patel & Amarsanaa, 2000). Traditional contraceptive methods include periodic abstinence and withdrawal. Female sterilization is not used as a contraceptive method although it may be performed in case of a health risk. Male sterilizations are not performed at all (Patel & Amarsanaa, 2000).

Mongolia has made abortions legal since the late 1980s. The Population Policy of the Mongolian Government states:

“Use of abortion as a method to avoid unwanted pregnancy should not be encouraged; abortion should be performed on the basis of permission from hospitals and family members for the sake of their well being, and in safe medical conditions...” (NSO et al., 1999, p. 104).

However, before other methods of contraception were available, abortion was utilized, as a form of contraception and this method is still prevalent today. This becomes evident in statistics from the National Reproductive Health Survey conducted in 1998. The MOHSW found that there were 9,135 abortions performed in 1998 or one abortion for every five births. However, that survey did not include private clinic statistics and it is more likely the number of abortions performed approximated 13,000 (Patel & Amarsanaa, 2000). Ninety-two per cent (92%) of women had been married the last time they had an unwanted pregnancy. Seventy-seven per cent (77%) of women surveyed were married when they terminated their last unwanted pregnancy. Urban and more educated

woman are more likely to have an abortion, probably due to their desire for smaller families. Among the women that terminated their last unwanted pregnancy, 71% were urban women (NSO et al., 1999).

There has been a rapid increase in sexually transmitted diseases (STDs) in Mongolia. The NSO et al. (1999) reported that the prevalence of syphilis is 5.6 per 10,000 people and has increased by 66% from 1989 to 1998. Gonorrhoea has increased 56% respectively over ten years to a rate of 16.3 per 10,000. The prevalence of trichomoniasis is 11.4 per 10,000 (Patel & Amarsanaa, 2000). However, these figures are likely to be major underestimates due to diagnostic limitations, low screening, under reporting, and service biases (UNFPA, 2000; Hatcher, Stewart, Cates, Stewart, Guest, & Kowal, 1998). For example, chlamydia tests are only given when vaginal discharge persists after standard antibiotic treatment for gonorrhoea despite the fact 80% of chlamydia infections are asymptomatic among women (Government of Mongolia & United Nations, 1999, University Health Centre, 2000). There is a lack of testing kits. Men do not access health centres for STD treatment as the services are primarily gynaecological and can be stigmatizing (Government of Mongolia & United Nations, 1999). In fact, it is common to self-treat an STI with antibiotics to avoid the health care system and embarrassment (UNFPA, 2000).

Despite these discrepancies, an increasing trend of STDs is evident. Increasing sexually transmitted infections indicate that people in Mongolia are engaging in risky behaviours such as unprotected sex, making them vulnerable to HIV infection. To date, only two cases of HIV have been reported in Mongolia, transmitted by foreigners. One person has already died of AIDS, which the government made public knowledge (Reilley et al., 1999). The threat of HIV/AIDS is very real in Mongolia with an increasing number of cases at its borders with China and Russia.

A recent survey conducted by the Mongolian MOHSW and the *Medecins sans Frontieres* (MSF) extensively assessed sexual knowledge, attitudes, and behaviours of youth in Mongolia (Reilley et al., 1999). This survey was followed by focus groups to further understand the attitudes and motives that drive these behaviours (Oyungerel, Reilley, & Sanger, 1999). The findings from this survey and focus group will be briefly reviewed below.

According to Reilley et al. (1999) 4% of respondents had sexual intercourse at age 15, whereas all respondents had sexual intercourse by age 25, due to a low average age at marriage. Men reported having multiple partners eight times more than women did. Almost 80% of unmarried respondents did not use any form of contraception the last time they had intercourse. Seventeen percent (17%) of those who did use contraception used condoms.

Reilley et al. (1999) illustrated that Mongolia's young people have many knowledge gaps about HIV / STDs and birth control. Almost all of the people that responded to the survey are aware of AIDS, know that it is transmitted by sexual intercourse or sharing needles, and that it is fatal. However, misconceptions about other modes of transmission for both HIV and STDs are prominent. Half of respondents reported they would not feel comfortable if they met someone with AIDS. The majority (60%) of respondents felt that they were not educated well enough about AIDS. Although most youth believed that condoms could prevent AIDS, fewer believed that condoms were an effective form of birth control. Thirty-nine per cent (39%) believed that condoms do not provide sufficient protection from STDs. Most of the respondents (77%) of participants felt that they did not know enough about STDs. Only half of the women reported to have sexual experience knew how to use a condom correctly (Reilley et al., 1999).

Talking openly about sexual issues in Mongolia is almost taboo. Accessing information on reproductive health and STD treatment is difficult due to the fear of being stigmatized. Men find buying condoms embarrassing. Women felt that buying a condom implied that they were sexually promiscuous (Oyungerel et al., 1999). Almost half (46%) of respondents believed that women should be responsible for contraception and 41% considered it the responsibility of both partners. Two-thirds of respondents would be glad if their male or female partner offered to use a condom. Oyungerel et al. (1999) found that there are still some existing barriers to use, such as embarrassment when buying condoms, the perception that condoms reduce male pleasure, and difficulty with condom negotiation. Further, there are obvious contradictions where gender roles are involved; socially, women are responsible for contraception but there are widespread barriers to

accessing condoms, negotiating their use, and proper use (Reilley et al., 1999; Oyungerel et al., 1999).

In many countries where the incidence of HIV/AIDS is low, the level of awareness and condom use is also low. Despite the fact that the incidence of HIV/AIDS in Mongolia is very low, awareness of AIDS as a sexually transmitted disease is high (NSO et al., 1999). This situation is attributable to a responsive government and the proactive work of the NGOs working in Mongolia and presents a unique opportunity for prevention efforts. The government has identified the control of communicable diseases including STDs and HIV/AIDS as a priority area for the health sector. The MOHSW is also attempting to make a shift to primary health care with improved intersectoral collaboration and community participation (Government of Mongolia & UN, 1999). To this end, the MOHSW initiated a “Health Promoting Schools” programme in 1997 with the co-operation with the Ministry of Education to heighten health awareness. The Health Management Information and Education Centre (HMIEC), a department within the MOHSW, has worked with many non-governmental organizations (NGOs) partners to develop a formal health curriculum for secondary schools in 1998 (Health Sector Review). Some of those partners included the United Nations Population Fund (UNFPA), the National AIDS Foundation, *Deutsche Gesellschaft Fuer Technische Zusammenarbeit* (GTZ), and *Medicins san Frontiers* (MSF). HMIEC also has a television studio that airs regular programming on a number of health topics, including reproductive health. Therefore, In terms of the AIDS epidemic, Mongolia is in the unique situation to maximize preventative efforts, learning from case studies from other countries.

CHAPTER 3

Literature Review

This literature review aims to understand structural, social, cultural, and individual factors that determine sexual health, with special reference to developing countries. Social Learning Theory is used to understand the interactions of these sexual health determinants and provides a conceptual framework for health education interventions, including peer education. Within this context, some of the claims of peer education programs and their successful criteria are examined.

Determinants of Sexual Health

The World Health Organization describes health as “a state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity” (Last, 1998, p.4). Health is a multi-dimensional phenomenon that is dependent on the interaction between individuals and their social and physical environment (Last, 1998). Given these holistic definitions, health is determined not only by formal health services, but by biological and genetic endowment, social networks and structures, culture, education, and physical environments among others. Definitions of sexual health also adapt a complex and holistic approach. The Sexual Information and Education Council of the United States (SIECUS) defines sexual health as:

“Human sexuality encompasses the sexual knowledge, beliefs, attitudes, values, and behaviour of individuals. It deals with anatomy, physiology, and biochemistry of the sexual response system; with roles, identity, and personality; with individual thoughts, feelings, behaviours, and relationships. It addresses ethical, spiritual, and moral concerns, and group and cultural variations.”

(SIECUS, 2000, www.siecus.org/pubs/cnct/cnct0001.html.)

These multidimensional definitions of health and sexual health include the many levels of interactions and relationships among a broad list of determinants. There is a substantial body of literature that describes health and health promoting interventions in developing countries with reference to HIV/AIDS. Among this literature is the view that

there are three major layers of factors: structural, social/cultural, and individual that have been contributing to the HIV epidemic (MacPhail & Campbell, 2001; UNAIDS, 1997). Many HIV prevention efforts have focused on the individual factors of knowledge, attitudes, and behaviour, but their impact on the epidemic has been limited (MacPhail & Campbell, 2001). An individual focus presumes that sexual behaviour is the result of a rational decision-making process based on knowledge. What these efforts neglect to recognize is that “knowledge, attitudes, and behaviour are constructed and negotiated within social and cultural contexts” (MacPhail & Campbell, 2001, p. 1614). Therefore, understanding each level of factors in Mongolia will help define the objectives, roles, and design of a (peer-led) sexual health education intervention program in Mongolia.

Structural Factors

A growing volume of literature is supports the argument that structural factors are a major contributor to the HIV/AIDS epidemic and may be stronger than an individual’s personal desire to protect his/her health. Structural factors are those social structural inequalities, policies, and institutional practices that make certain populations or groups vulnerable to HIV infections (Parker, Easton, & Klein, 2000). Specifically, economic (under)development, political instability, and gender inequalities have been identified as the major factors facilitating HIV transmission and are generalizable worldwide (Parker et al., 2000).

Poverty has been identified as a key force behind the HIV epidemic. On an individual level, poverty can prevent people from buying condoms (MacPhail & Campbell, 2001). On a policy level, a country’s economic development impacts many health determinants including education and health care and thereby may create other social inequities (Last, 1998). Structural adjustment programs (SAPS), a condition on international loans, have negatively impact the health of a developing countries, particularly the poor, because their policies have decreased spending on health services, including, STD education and testing. These policies determine how many condoms may be available in a country. For example, economic reforms in Zimbabwe in the 1990’s reduced the availability of condoms (Parker et al., 2000). Mongolia has also undergone

many economic reforms in the 1990's, weakening government and NGOs' ability to implement health activities. Inconsistent availability of condoms has also been a barrier to safer sex practices in Mongolia (UNICEF, 1999).

On a population level, economic and political forces have caused people to migrate to different places to find employment. HIV transmission has been facilitated by migration as it brings people that have been infected with HIV to populations that have not been exposed to the virus. There are many examples and reasons for population migration. A lack of employment opportunities at home has caused men to become seasonal workers in other locations. Male migrant labourers may frequent sex workers while away and transmit HIV to their wives upon their return to home, thereby spreading HIV from higher (i.e., urban) to lower incident (i.e., rural) areas (Parker et al., 2000). Similarly, in the absence of their husband's support, women who stay at home with the family may be faced with severe economic hardships that make them turn to sex work. Parker et al. (2000) cite how globalization and SAPS have contributed to rural to urban migration by encouraging industrialization, which are generally located in urban areas. SAPS have also funded dam projects in Ghana, Brazil, and Sub-Saharan Africa that have caused the dislocation of millions of people that were living in the flood area, forcing people to look for new employment, including sex work. Dislocation caused by war has also been found to increase HIV transmission, for example, among Ugandans (Parker et al., 2000).

Recently, there has been increased internal migration within Mongolia due to relaxed regulations. As the nomadic lifestyle has been difficult with the private ownership of land (farmland used to be owned by the state to be used by nomads), unequal distribution of wealth, and harsh winters that have devastated livestock, more nomadic Mongolians are migrating to urban areas to work for the growing industrial sector (Greenway et al., 1997). Since 1989, 30% of nomadic Mongolians have moved to work in urban centres (National Statistics Office et al., 1999).

Socio-Cultural Factors

Health is greatly influenced by one's social environment as it determines constraints, models, and support systems for behaviour. Social determinants of health may include one's occupation, socio-economic status, social networks, and culture (Last, 1998). For example, the sexual division of labour determines how society allocates occupations (and the financial value given them) among men and women. This division of labour is characterized by greater socio-economic risk factors for women such as poverty, lower education level, more underemployment, and more homelessness. Inequities associated with greater division of labour expose women to more socio-economic risks that will result in poorer health outcomes. All of the above risk factors have been linked to women's vulnerability to HIV infection outcomes (Wingood & DiClemente, 2000). Another example of socio-cultural factors is how social networks (i.e., family, friends, and co-workers) provide models of behaviour and education. They also act as a coping mechanism that can contribute to the mental health of an individual (Last, 1998).

Social and cultural factors are often intertwined. Culture encompasses the values, beliefs, and ideals of a population (Mensah, 1996) and "describes the socially acquired and transmitted behaviour patterns of an ethnic group, community, society or nation" (Last, 1998, p.241). Culture creates social norms and the attachments to certain meanings and symbols that make a culture unique. For example, the age of sexual initiation varies greatly among different cultures, economic groups, and educational backgrounds (UNAIDS, 2000). In the case of culture, traditional or religious values and the function of family may dictate whether premarital sex is unacceptable, at what age men and women should be married, and the size of a family. Also, cultural values can make topics like sex taboo and create the language through which norms for sexual behaviour is communicated.

The concept of gender is a socio-cultural construct and the imbalance between genders that occurs in many countries have been known to put men and women at risk for HIV (Rivers & Aggleton, 1999; Wingood & DiClemente, 2000). Gender imbalance refers to the power balance between women and men as assigned by a society that identify what

is masculine and what is feminine (UNDP, 2000). Social psychologists define power as “having the power to influence the action of others” (Wingood & DiClemente, 2000, p. 543). Women’s subordinate position in a society may be controlled by social mechanisms. For example, many traditional marriages make women financially dependent on their male partner, which reduces their power of self-determination. Further, the high value placed on female virginity in some countries may encourage families and communities to keep young girls’ knowledge on sexual health matters limited. This power imbalance can make negotiating safer sex more difficult for women, especially as using condoms requires male co-operation. Wingood and DiClemente (2000) argue that “the greater social power that men have in sexual decision making limits women’s ability to use condoms” (p.549). Many countries in Africa and Asia indicate that even when young women are aware of safer sex practices, they rarely have the power to enforce them (Rivers & Aggleton, 1999).

In some instances, gender roles emerge that dictate how women and men should express their sexuality, often creating double standards and put both at risk for HIV infection. Gender roles restrain women’s sexuality by emphasizing virginity, keeping them less educated about sexual health matters and not allowing women to initiate a sexual encounter (i.e., having sex on a man’s terms). Women may want to protect their virginity by engaging in other high-risk sexual behaviour such as anal sex. Older men who are very sexually experienced may seek women who are virgins or less experienced, passing on infections (Rivers & Aggleton, 2000). On the other hand, concepts of masculinity and virility put boys at risk of early sexual initiation, unprotected sex, and having multiple sex partners (Wingood & DiClemente, 2000; Rivers & Aggleton, 2000).

Individual Factors

Knowledge, attitudes, and abilities are contributors to the adoption and maintenance of health behaviours (Last, 1998). Desirable health behaviours include postponing sexual initiation, condoms negotiation, and using condoms correctly and consistently. For researchers, information on knowledge, attitudes, and skills related to sexual health is essential to identify populations that are vulnerable to HIV, STDs, and

unplanned pregnancy and has been a primary method of assessing changes over time as a result of prevention efforts (UNAIDS, 1997). For educators, information on knowledge, attitudes, and skills related to sexual health is key to developing behaviour changing interventions that are specific to the needs of the target population (Hatcher et al., 1998).

An individual's reproductive and sexual health decisions occur over the life course and rely on one's ability to make informed health choices about their sexuality (Hatcher et al., 1998). Decisions based on sound knowledge are critical for healthy choices (Hatcher et al., 1998; Serovich & Greene, 1997). People need to know the factual information (i.e., how their body works, how pregnancy occurs, and how STDs are transmitted) in order to take appropriate action for their health. However, Serovich and Greene (1997) report the link between new knowledge and the practice of risk-reduction behaviours is weak and that one's attitudes and skills must also be addressed.

Sexual attitudes are a person's perceptions towards their sexuality and the consequences and risks involved in sexual expression. Sexual attitudes are greatly influenced by the social and cultural environment and are a predictor of one's behaviour. During adolescence, many young people inaccurately assess their personal risk as low as they engage in experimentation of high-risk behaviours such as unprotected intercourse because they hold the 'it can't happen to me' attitude (Serovich & Greene, 1997). Also, one's subjective norm (i.e., the perceived approval of significant others about the behaviour) is critical to the success of sexual behaviour interventions. More than any other period, adolescents will reference the sexual behaviours of their peers, as they are still unsure about how to behave (Reed & Weinberg, 1984). For example, DiClemente (1990) found that the decision for adolescents to use condoms was determined by the perceived reference group (e.g., friends, classmates) behaviour. Sexual initiation is highly associated with what is perceived as normative in one's peer group (Brooks-Gunn & Furstenberg, 1989). Therefore, to change attitudes and affect behaviour, information provided must be immediately relevant to the choices and the social environmental pressures that young people face. Therefore, attitude assessments are key to developing appropriate educational material that will promote responsible sexual behaviour.

"People change behaviours more often as a result of new skills than of new knowledge" (Hatcher et al., 1998, p. 249). Skills are the wheels that put knowledge into

action. Sexual skills include sexual decision-making, communication and negotiation, and alternative activities for intercourse. The ability to critically analyze sexual attitudes portrayed in popular culture and media is another important skill that promotes healthy sexual behaviour (UNAIDS, 1997).

Social Learning Theory

Social learning theory helps us understand how new knowledge, attitudes, and skills are learned, modified into behaviours, and maintained without forgetting the influence that structural and socio-cultural factors may have on this process (Balassone, 1991). It addresses the mutual interaction between individual and environmental factors (i.e., structural and socio-cultural factors) that may contribute to learning and employing health behaviour (Balassone, 1991). As such, social learning theory has been applied to many sexual health interventions including peer-led programs (Balassone, 1991; UNAIDS, 1997; Hagenhoff, Lowe, Hovell, & Rugg, 1987).

Central to social learning theory is the concept that human function is a result of the continuous interaction of personal factors, overt behaviours, and environmental influences. This continuous interaction is termed reciprocal determinism (Bandura, 1977; Hjielle & Ziegler, 1992; see *Figure 3.1*). Personal factors that influence human function (i.e., internal factors) include the cognitive influences such as beliefs, expectations, consequences, and self-perceptions. Environmental influences encompass rewards, punishments, social and cultural norms, the presence of role models, and the availability services. Overt behaviours include one's ability to communication, negotiate, and interact. Bandura (1977) proposes that there is a constant and bi-directional interplay between these three factors (as indicated by the bi-directional arrows in *Figure 3.1*).

According to social learning theory, personal factors are simply potentialities that must be activated to have influence (Bandura, 1977). For example, knowing that condoms provides protection from STDs will not confer protection unless that knowledge is translated into the behaviour of using one for every coital encounter. Bandura (1977) asserts that personal factors can create, change or maintain one's behaviour (e.g., believing that condoms reduce the pleasure of intercourse may make someone not use a

condom) as well as create or impact one's immediate environment (e.g., one's perceptions and behaviour may select for the presence of particular role models).

Environmental factors also have no effect unless someone reacts to them or acts upon them. For example, having STD treatment services will not cure someone with an STD until they go to the clinic (i.e., overt behaviour). Likewise, the social norm that women should be subservient to their male partner does not put women at risk for HIV until a woman believes that subservience is an appropriate action (i.e., personal factor).

Finally, overt behaviours also have a feedback mechanism that can influence personal and environmental factors. For example, successfully negotiating condom use will have a positive impact on one's self-efficacy (i.e., personal factor) to believe that it can be done again (Hjielle & Ziegler, 1992). Behaviour also has the power to change one's environment. For example, if a person interacts with teachers in a polite way, this will affect how the teachers choose what rewards or punishments the student deserves. Behaviour can also change the environment at a community level, such as the collective power of students advocating for more sexual health information (Bandura, 1977).

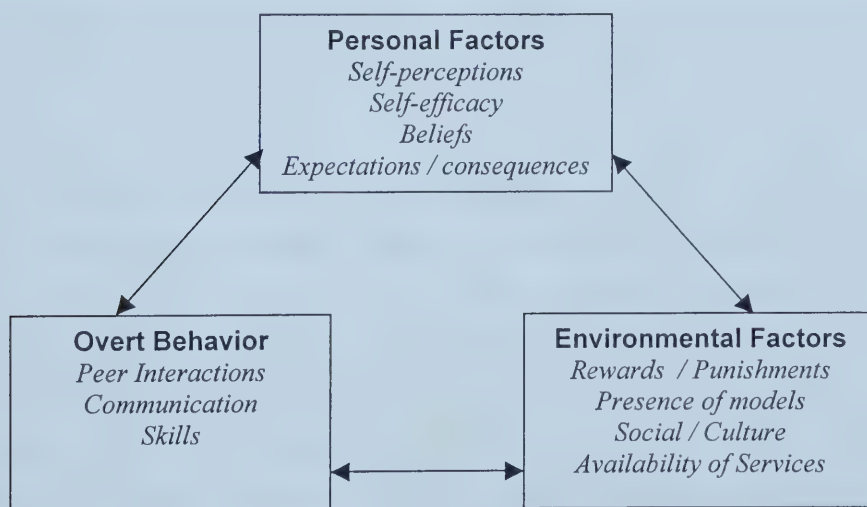


Figure 3.1: Reciprocal Determinism (Hjielle & Ziegler, 1992)

Social learning theory provides a framework in which the three layers of sexual health factors (i.e., structural, socio-cultural, and individual factors) may interact. In this

framework, environmental factors would encompass structural and socio-cultural factors, acknowledging the influence of gender norms, health policies, and societal values together. Individual factors (e.g. knowledge, attitudes, and personal skills) would be divided among one's overt behaviour and personal factors.

According to this framework, Bandura (1977) defines freedom as “the number of options available to people and the right to exercise them” (p. 201). Therefore, everyone has the freedom to make choices about their sexual health but every factor (i.e., personal, behavioural, or environmental) has the potential to provide or eliminate options. For example, not knowing how to use a condom is going to limit one's ability to practice safer sex. Likewise, not having condoms available will also reduce the options for safer sex. This concept is what has promoted the need for sexual education: Survey evidence from the United States in the mid- seventies showed the young people's knowledge about sex and contraception were low, so educational programs were implemented so that people had the option of preventing unwanted pregnancies (Blau & Gullotta, 1993). As demonstrated in the previous sections, the socio-cultural and structural contexts may eliminate options. Therefore, health-promoting interventions must acknowledge both personal and environmental factors to make the program's objectives realistic and to maximize the options available for people to make healthy choices.

Social learning theory also identifies how people acquire, learn, or alter behaviours (Hjielle & Ziegler, 1992). Social learning theory proposes that people learn behaviours through anticipated consequences, observational learning, and reinforcement. First, people may acquire behaviour like condom use based on the anticipated consequence of getting pregnant. One does not have to become pregnant first to realize that this is important. Second, people learn through observation or modelling. For example, if a group of students observe a condom demonstration, they are more likely to use condoms more correctly rather than just reading the package (Sherrill, Golec, Hancock, Sarawato, & Thompson, 1993). However, there is a process of observational learning that determines the correct execution of the observed behaviour. The observer must accurately perceive the behaviour, remember it, and symbolically translate it so it can be used in new situations, and have a positive reinforcement to ensure its continued use. There are many different types of reinforcement. External reinforcements might

include peers encouraging condom use. An example of vicarious reinforcement might be a classmate successfully negotiating activity options over sex and, by relaying that experience, may encourage his/her friends to do the same. Self-reinforcement includes awards given to one's self, such as having good self-image for negotiating safer sex (Hjielle & Ziegler, 1992).

Adolescent Vulnerability

In most countries, young people are sexually experienced by the age of 20 (Rivers & Aggleton, 1999). It is estimated that half of sexually transmitted infections worldwide occur among young people aged 15 to 24, making young people the most vulnerable age group to STDs and HIV (Rivers & Aggleton, 1999). In developing and developed countries, young people are made vulnerable to STDs and HIV because of their age and social status, which often limits their access to information, services, and resources. Often health care workers are not trained to deal with issues that are unique to adolescent health and therefore, may discourage treatment. Because of their age, access to contraception and condoms are difficult. Policies and social values meant to control their sexuality may limit the amount of sexual health information that is available to young people (Rivers & Aggleton, 1999). Also, other factors such as gender imbalances and social norms that effect everyone's sexual health may have a heightened effect at this age as young people may be unsure of what behaviour is appropriate (Reed & Weinberg, 1984). Higher frequency of drinking among young people has also been identified as high-risk behaviour that increases their vulnerability to STDs and HIV (Crael, Cleland, Deheneffe, Ferry, & Ingham, 1995).

Interventions that promote sexual health are most beneficial at this age because educating youth before sexual initiation had been proven to prevent teen pregnancies and STD infection before unsafe sexual behaviours are ingrained (UNAIDS, 1997). Early efforts also help young people prepare for their first experience as most teens do not plan to become sexually active and don't usually foresee their first sexual experience (Brooks-Gunn & Furstenberg, 1989). In South Africa, prevention efforts are thought to be most effective if directed at people below the age of 16 (MacPhail & Campbell, 2001).

Sexual Education

Young people acquire sexual health knowledge, attitudes, skills, and behaviour in two ways: formal education (i.e., school) and informal education (i.e., learning thorough media and social networks of family and friends.). Informal education may include skill and behaviour modelling by parents, friends, classmates as well as media and popular culture. Young people that have a close, supportive relationship with their parents are more likely to have a later onset of intercourse (Brooks-Gunn & Furstenberg, 1989). However, young people in North America receive most of their sexual health information from their friends (Blau & Gullotta, 1993). Unfortunately, informal means of informing young people about sexual matters may be inadequate due to misinformation, sexual taboos prevalent in many cultures, a reluctance to discuss personal experiences and feelings in the family or lack of concern for HIV/AIDS.

In North America and Western Europe, sexual education was once the task of the family to impart to the adolescent, but over the last thirty years, the primary responsibility of sex education has shifted to the school (Brooks-Gunn & Furstenberg, 1989; McKay & Pietrusiak, 1998). Most parents in North America support sex education in the schools (Brooks-Gunn & Furstenberg, 1989). Sexual education among youth does not result in increased sexual activity but may lead to the adoption lower risk, safer sexual practices (Hatcher et al., 1998; UNAIDS, 1997). Countries that discuss sex more openly and teach birth control in schools boast lower birth rates, and low birth rates are associated with low abortion rates (UNAIDS, 1997).

Unfortunately, sex education in the school may not be very comprehensive. In the United States, typical sex education courses are 8 to 10 hours in length and focus on the human reproduction system, contraception, STD/HIV transmission, and consequences of pregnancy (Blau & Gullotta, 1993).

Because messages from family, friends, schools and society influence sexual behaviour, sexual health education must be comprehensive to do more than impart knowledge, but to develop skills and address collective attitudes as well. It has been shown that programs that combine education with skill development delay sexual initiation (Hatcher et al, 1998). Consistently, studies show that there are knowledge gaps

regarding adolescents' own views and perceived needs regarding sexual health, indicating that school based education alone is inadequate. In America, three in five teens report that they do not receive enough information on contraception and much of that information comes too late (Hatcher et al., 1998). In Canada, two in five teens feel they do not receive enough sexual education (McKay & Holowaty, 1997). Indeed, knowledge gaps also exist among Mongolian youth (Reilley et al., 1999).

Peer Education as an Intervention

Peer education has been used as an intervention to address the knowledge gaps among young people at college and high schools and in a number of different countries (UNAIDS, 1997; UNAIDS, no date). John Sciacca (1987) defines peer education as, "the teaching or sharing of health information, values and behaviours by members of similar age or status groups" (p.4). Peer education programs may work at any age or status group, but many of the peer education programs have worked with adolescents (Milburn, 1995). Peer education is a means of information delivery, working through existing communication channels and social networks of peers. There are different definitions of the involvement of the adolescent peer educator that may include the peer counsellor, teacher, and advocate. Their involvement with the target group may be formal (e.g., classroom settings) or informal (e.g. community settings) (Shiner, 1999).

There are many examples of school-based peer education programs that highlight the special function of peer-led education in school. Dunn, Ross, Caines, & Howorth (1998) conducted a study of a school based education program that used three different educators to assess how effectively they relayed sexual health information to the students. Teachers, community health nurses, and adolescent peer educators led sexual health classes to junior high students in Ontario, Canada. Both the community health nurse-led groups and the peer educator-led groups scored significantly better than the teacher-led groups on HIV/AIDS prevention, attitudes, and behaviour intentions. The peer educator-led groups scored the best out of the three groups on predictors of future condom use. In a recent study, Mellanby, Rees, and Tripp (2000) reviewed thirteen comparative studies for the behavioural effectiveness between peer and adult taught health education programs.

Results determined that peer-led interventions were at least as, or more effective than, adult-led interventions among the majority of the trials.

Peer-led education may be successful because it taps into existing social processes for obtaining information on sexual health. Peer interactions occur much more frequently and are more in-depth compared to interactions with other people such as teachers when discussing sexual matters (Milburn, 1995). Some adolescents may feel more comfortable receiving sexual health information from peers rather than adults because of the respect and power differentials that exist between the two groups (Dunn et al., 1998). Any educator must be deemed credible in order to be influential. This is achieved by being perceived that (a) the educator is able to share and understand the attitudes and experiences of the target group and (b) the educator has relevant information for those experiences. Being perceived as sharing the same attitudes and experiences is perhaps the most influential justification for credibility. Information from peers may be considered more credible, no matter how true, because they hold similar attitudes and values (Turner & Shepard, 1999). On the other hand, teachers who may have very relevant information may never be deemed totally credible because it is very unlikely that they share the same experiences and attitudes. However, if an adolescent peer educator does not have relevant information, they will not hold the attention or the esteem of their peers for long.

Critical Success Criteria for Peer Education

Despite the advantages of peer education, it is an intervention that frequently fails (Walker & Avis, 1999). There is the existing notion that peer education is a trouble free intervention where students are trained on a health topic and then left to disseminate that knowledge through the naturally occurring processes of peer interaction. However, there are a number of criteria that need to be met to make a peer education program successful: (a) it must be driven by theory, (b) there must be a recognition of the environment and its potential constraints, (c) it must include peer development, (d) it must have multi-level support, and (e) must utilize evaluation tools (Walker & Avis, 1999; Turner & Shepard, 1999; Milburn, 1995).

The first criterion for a successful peer education program is that it is driven by theory. It is often the lack of a theoretical framework that is sensitive to the socio-cultural context that negatively affects the progress and evaluation of a peer education program (Milburn, 1995). Rationale for peer education has historically been grounded in social learning theory, social inoculation theory, and differential association theory. Social learning theory is particularly favourable for peer education because it recognizes the impact of the socio-cultural context (Milburn, 1995). UNAIDS cites it as an essential component of successful health education programs around the world (UNAIDS, 1997). Social learning theory is useful because it acknowledges the environmental context of learning and recognizes the importance of role models and reinforcement in the learning process. Based on the tenets of social learning theory, the peer educators must act as positive role models to reinforce health behaviour and contribute to a healthier social context (Dunn et al., 1998; Turner & Shepard, 1999). Also, peer education can be beneficial to the peer educators themselves and empower those involved in the program (Turner & Shepard, 1999).

The second critical criterion is recognition of the environment in which the program occurs. The setting in which the program is situated should govern the design and the objectives of the peer education program (Walker & Avis, 1999). For example, school-based peer education will operate differently than working with street youth. Social learning theory highlights the influence the environment and its constraints will have on the behavioural outcomes of the program. By assessing the environment, relevant information and skills can be relayed and realistic goals for the program can be set. For example, if condoms are not available in a country, then it is a waste of time teaching students how to use a condom and evaluating whether students used condoms the last time they had sex. Instead, the program can focus on sexual activity options and chose related outcomes.

Thirdly, peer education programs must include peer development. According to Shiner (1999), peer development describes the personal development of the peer educator. Peer development can only occur if the peer educators have ownership of the program and define their own needs. Shiner (1999) also distinguishes the difference between peer development and peer delivery. Peer delivery uses peers to deliver

information. This information may have been imposed on them by adults or be developed by them. Milburn (1995) questions the 'adultist' agendas of many peer education programs and Walker and Avis (1999) cite the lack of peer involvement at the development stage as a common reason for program failure.

Another important criterion is the need for multi-level support for the peer education program. This support can consist of proper training and support for the peer educators themselves to the involvement of many community agencies in the delivery of the program. Other supports include a co-ordinator in place to supervise and motivate the peer educators and training that is broad in scope and consistent with the goals of the program (Walker & Avis, 1999). Peer educators should have good feedback mechanisms (Sherill et al., 1993). A broad range of community agencies should share ownership and responsibility in the program to promote funding opportunities, bringing fresh ideas to the program, and keep program publicity positive (Walker & Avis, 1999).

Lastly, peer education should utilize strong evaluation tools that remain true to the program objectives (UNAIDS, 1997). Milburn (1995) asserts that most peer education programs lack good evaluation that clearly links the intervention with outcomes. Most peer education programs have evaluated individual explanations of sexual behaviour such as changes in knowledge, attitudes, and behaviour (Mellanby et al., 2000). These evaluations have been met with limited success, as these indicators cannot be exclusively linked with changes in behaviour. Furthermore, they dismiss the structural and socio-cultural determinants of health (MacPhail & Campbell, 2001). Also, knowledge, attitude, and behaviour surveys neglect to evaluate changes in the community (e.g., school) as a result of a participatory intervention like peer education. MacPhail & Campbell (2001) suggest evaluating changes in other determinants of sexual health such as the collective perceived vulnerability, perceived norms, and existing social pressure of the target group using qualitative research methods. Good evaluation will promote the program by setting attainable goals and foster funding opportunities.

International Peer Education Programs

Many international peer education programs have proven to be successful in a wide range of cultural settings and countries including Africa, China, and Southeast Asia. Evidence shows that good quality sexual health peer education programs helped delay first intercourse and promoted responsible and safe sexual behaviours (UNAIDS, 1997). The most effective international programs are also based on the above criteria (UNAIDS, 1997). Recent projects in Mongolia have determined that peer education is a culturally appropriate medium to confer sexual health information to commercial sex workers and college students (Reilley et al., 1999).

CHAPTER 4

Study Design

Purpose & Research Questions

Upon examination of the three layers of factors for sexual health in Mongolia, the socio-cultural aspects of sexual health are known the least. To date, Reilley et al. (1999) had adequately quantified some of the knowledge, attitudes, and behaviours of young people in Mongolia. Some of the structural factors in Mongolia such as political and economic instability and geographic proximity makes it susceptible to an HIV epidemic (Government of Mongolia, UN, 1999). However, information about the culture of Mongolia is limited, especially current information that encapsulates the changes that Mongolia has seen in the last ten years. Furthermore, the culture of sexual health has not been described. What is known is that the topic of sex has been taboo in Mongolian culture, but this phenomenon has never been investigated (Reilley et al., 1999; Patel & Amarsanaa, 2000). Because of recent political, economic, and social changes and more open times, views of sex and sexuality are said to differ between young people and their parents (Reilley et al., 1999). The current socio-cultural context of sexual health among youth in Mongolia needs to be explored, specifically the socio-cultural factors, if culturally appropriate interventions and policies that meet the needs of this very young population are to be implemented. Therefore, the first exploratory research question is:

What is the socio-cultural context of sexual health for youth in Ulaanbaatar, Mongolia?

Although their awareness about HIV is high, Reilley et al. (1999) found that Mongolians have many misconceptions about the transmission and treatment of HIV and STDs and about condom effectiveness. They also found that the youths' primary source of sex information comes from their friends. Peer education is an intervention that has been found to address gaps in knowledge, especially regarding sexual health and can be a cost-effective (Turner & Shepard, 1999). Many international peer education programs have proven to be successful in delaying first intercourse and promoting responsible and safer sexual behaviours (UNAIDS, 1997). By assessing environmental context and the

degree of multi-support for a peer education program through consultation with the primary stakeholders (i.e., health staff, teachers, and students), culturally appropriate interventions can be determined and realistic outcomes of the project can be set. Thus, the second and third research questions are:

Is a peer-led sexual health education program an appropriate intervention for youth in Ulaanbaatar, Mongolia?

How would a peer-led sexual health education program be tailored to meet the needs of urban Mongolian youth?

This study used qualitative research methods to explore and describe the socio-cultural context of sexual health and the appropriateness and design of a peer education program. Since little is known about the socio-cultural context of sexual health or the application of peer education among youth in Mongolia, a qualitative study design is best suited to broadly explore these topics and provide new insights that may be used for health-promoting interventions for Mongolians.

Research Approach

Focus groups were used as the primary research tool to answer these research questions. Focus groups are discussions among a small group of people that bring understanding to a particular issue. They are composed of groups of people that all have something in common that are related to the focus group topic (Krueger & Casey, 2000). The difference between a collection of individual interviews and a focus group is the “group effect” (Carey, 1995; Kidd & Parshall, 2000). Rich qualitative data is created by the synergistic effect of people discussing an issue, commenting on each other’s point of view, and sometimes debating perspectives (Kidd & Parshall, 2000). A focus group discussion “has the potential to uncover important constructs which may be lost with individually generated data” and is sensitive to cultural values and group norms (Kingry, Tiedje, & Friedman, 1990, p. 125; Kitzinger, 1995). Focus groups promote self-disclosure among participants by breaking the ice for shy participants and providing

mutual support to determine what people really think and feel about the topic, even those topics that are taboo (Krueger & Casey, 2000; Kitzinger, 1995).

Essentially, the research questions gave rise to two objectives of the focus groups: (a) to explore and describe the culture of sexual health and thereby determining the appropriateness and fittingness of peer education as an intervention, and (b) to gather opinions about the design and development of such a program. These objectives determined the overall design of the study, from framing of the study questions, selection of the participants, determining the size of the focus group, how many focus groups to conduct, strategies for data analysis, and plans for presentation of results (Carey, 1995; Krueger & Casey, 2000).

Design

A multiple category focus group design was used that allows the researcher to compare responses between different categories of participants (Krueger & Casey, 2000). Because this study aimed to examine the multi-level support of a peer education program, health staff, health teachers, and students were identified as the primary stakeholders that would provide differing, but important perspectives on the research questions and, therefore, should participate in the focus groups separately. Recognizing the sensitivity of the issue and possible gender roles, the students were divided by gender so comparisons could be made between girls and boys. While health staff and teacher perspectives added an important dimension to the research questions, student input was deemed most important and so they had twice as much discussion time. Teachers and students were recruited from two schools in Ulaanbaatar. (Details about how the two schools were recruited are available in the next chapter.) Two focus groups, one focus group with the teachers and one with the health staff from HMIEC, were conducted to address all the research questions. According to this multi-category design, six ‘consultative’ focus groups were conducted. Two focus groups, one male and one female, were conducted with the selected students focused on objective (a) (i.e., sexual health). One week later, two more focus groups were conducted with the same selected students that focused on objective (b) (i.e., program design). After the six consultative focus groups determine that

peer education is an appropriate intervention, a peer education program was implemented. After one month of program operation, evaluation focus groups with the original students participants that were trained as peer educators were conducted. This time, these focus groups were divided by school rather than gender and provided some feedback to the program design and peer development (i.e., objective b).

Sample

The goal of qualitative research is to get deep, rich information rather than superficial but generalizable findings that is pursued in quantitative research (Patton, 1990). Therefore, random sampling is not an appropriate technique. Sampling for qualitative data seeks to find participants that are most knowledgeable on the focus group topic. This is known as purposeful sampling (Sandelowski, 1995; Krueger & Casey, 2000; Patton, 1990). Purposeful sampling is not limited to demographic characteristics, but also events and experiences people may share (Sandelowski, 1995). For the purposes of this study, HMIEC staff, health teachers, and students were identified as stakeholders in a sexual health education program and participated in the focus group discussions. HMIEC staff participants were selected based on their expertise in adolescent sexual health and interest in the program. Teachers were selected based on the relevance of their teaching experience. Participants in the study conducted by Reilley et al. al (1999) reported that age 15 was an appropriate time to begin sexual health education lessons. Given these findings, the researcher felt that interest and participation in the sexual health education program might be best if students aged 15 to 17 were involved. Therefore, students (and future peer educators) aged 15 to 17, were selected for their communication skills, listening skills, comfort level with sexual health, and general openness.

There were eight focus groups conducted in total with eight participants in each focus group. Casey and Krueger (2000) recommend that academic focus groups be limited to six to eight people so that the researcher has more time to probe and get more in depth insights into the participant's discussion.

Question Guide

This study used a predetermined question guide for each focus group (Appendices 4.1 to 4.6). The purpose of using a question guide was to make the discussion focused but feel natural, comfortable and understandable. As the researcher did not speak Mongolian, using a structured question guide ensured that the moderators addressed the objectives of the focus group. A good question guide should ask clear, understandable, open-ended questions (Krueger & Casey, 2000). The question guides had a natural flow from one to another, moving from the general to the specific. This “funnel approach” is most effective when talking about sensitive issues (Rothe, 1994). However, ultimately the study objectives had higher priority than the pre-constructed questions. If an important topic arose that was not included in the guide or the discussion unfolded in an unanticipated manner, the pre-constructed questions were abandoned with the study objectives in mind. All translated question guides were reviewed by the research team for linguistic appropriateness and relevance to the participants. The translated guides were also piloted with similar peer groups to the participant categories to determine the socio-cultural appropriateness, clarity of the question guides, and provide practice for the moderators. The research team made necessary changes before the actual focus groups were conducted.

Research Team

The research team for the focus groups included the researcher, moderators, observers, transcribers, and translators. All members of the research team were essential to generating excellent, descriptive data.

Moderators

The success of the focus group is dependent on the skills of the moderator to create a safe, comfortable atmosphere in which to share ideas and opinions. The moderator must be knowledgeable in the topic area to be able to probe appropriately, have good listening skills, and be sensitive to the needs and perspectives of the participants (Krueger & Casey, 2000). For this study, four moderators were hired to

conduct all of the focus group interviews. The moderators were Mongolian, had interview experience, spoke English, and were sensitive to social and cultural factors (i.e. media, language, behavioural norms). The focus group moderator for the HMIEC group was recruited outside the host agency. All of the moderators were young (i.e., under the age of thirty) to make the students more comfortable. Same sex moderators were used for the peer educator focus groups that were split by gender.

The researcher conducted a training session with the selected moderators to review the objectives of the study, intent and meaning of the questions in the question guide, and ethical considerations. In addition, they received brief training on interview protocol such as greeting, ground rules, probing, word usage, participant control, and debriefing to ensure quality and consistency. They also received an interview guide (Appendix 4.1) that included interview tips, study objectives, and a checklist. The moderators were given an opportunity to review the question guide and contribute to the tweaking of the interview questions as they provided a valuable cultural perspective.

The moderator was required to complete a moderator report after each focus group to outline his/her impressions of the focus group participation and quality of comments generated.

Observer

An observer was present at each focus group to make notes of focus group participation, interactions, emotional input that audiotapes and transcripts could not capture. The observer completed a report after each focus group. When possible, the researcher was the observer with the help of a simultaneous translation.

Transcribers

Each focus group was audio taped. However, discussions on audiotape can be difficult to understand, especially if more than one participant talks at the same time. To circumvent this problem, the transcriber was present during the focus group to make notes of the discussion that were used to clarify the transcribing process.

Analysis Approach

Translated and transcribed focus groups underwent content analysis. Crabtree and Miller (1992) describe qualitative content analysis as codes that are derived from the data, and those codes are grouped into relevant themes. Labels and sub-themes are developed if necessary. Then data is matched to the themes to recontextualize them for description in the findings.

Ethical Considerations

Ethical approval for this project was granted by the Health Ethics Research Board B (University of Alberta, Capital Health Authority, and Caritas Health Group) in July 2000. Permission to conduct research in Schools 20 and 58 in Ulaanbaatar, Mongolia was arranged by HMIEC and granted by the school directors.

The Council for International Organizations of Medical Sciences (CIOMS) outlines some basic principles for conducting research in a developing country (Glantz, Annas, Grodin, & Mariner, 1998). Three principles are especially pertinent to this study: quality of informed consent, coercion, and the research benefiting the participants.

First, the researcher must recognize that the participants may be a vulnerable population to exploitation due to their economic, political, or educational situation. Children are also a vulnerable population as they lack the power to stand up to adult authority. As the student participants were minors, discussions with Dr. Dulamsuren, Director of HMIEC, and the school director clarified the appropriateness of school director consent versus parental consent for their participation. It was determined that it is culturally appropriate to use school director consent. Each school has an administrative board, which include elected parents that are to represent the community. As a spokesperson for the board (and therefore the opinion of the parents) the director can give consent for student participation. Each school director signed a consent form allowing the students to participate in the focus groups and the peer education program.

Informed consent must include anonymity, confidentiality, and volunteerism (Hills, 2000). Every focus group participant, including the students, was given an information sheet (Appendices 2.1 to 2.5) and consent form that permitted the researcher

to use and analyze information revealed in the focus groups for the program and for its anonymous results to be included in academic and community documents (Appendices 3.1 to 3.5). Given that the focus groups were small and confined to two schools, it was important that any information shared within the focus groups does not alter peer or student-teacher relationships. The information sheet explained that the researcher could not guarantee participant anonymity, but only made them aware of the risk involved and that certain steps were taken to reduce this risk, such as the use of agreed upon ground rules in the focus groups. Raw data (in the form of transcripts or audiotapes) were not to be revealed to any stakeholders, and the research team must sign a form binding them to not discuss any information with anyone but the research team. Finally, the consent forms explained that participation in the focus groups or the peer education program was strictly voluntary and that they were welcome to withdraw from the study and the program at any time. All consent forms were signed before the researcher.

The research must benefit those who are being researched (Glantz et al., 1998). Although the study findings may contribute to a body of knowledge or benefit others in other parts of the world, the research must be tied to the originating community and it must have a practical and viable application. Having the research questions tied to a possible peer education program ensures the participants that some relevant benefit would occur.

CHAPTER 5

Methods

Study Partnerships

In November 1999, Dr. Dulamsuren of HMIEC in Ulaanbaatar, Mongolia visited the University of Alberta through GTZ. It was at that time that the researcher met with Dr. Dulamsuren to talk about possible research in Mongolia including the need for and the cultural appropriateness of peer education to address sexual health issues. Once plans to pursue researching and implementing a peer-led sexual health program in Ulaanbaatar were confirmed, Dr. Dulamsuren agreed to be the researcher's field supervisor (See Appendix 1.2). Before the researcher arrived in Mongolia, Dr. Dulamsuren, currently Director of HMIEC, made some pre-entry arrangements such as finding a co-researcher and selecting the participating schools.

A co-researcher was needed as she had professional relationships that could facilitate the study and translate on behalf of the researcher as most of the teachers and students involved spoke little to no English. In addition, having a Mongolian work through the formative evaluation process while the peer education program was being initiated created a local expert on the subject. Dr. Dulamsuren chose Dr. Oyun of HMIEC to be the field co-researcher for the study. Dr. Oyun is Mongolian and was trained as a gynaecologist in Russia. She worked at HMIEC as a researcher and trainer on reproductive health issues. She spoke very good English, was open-minded, and had an excellent rapport with young people. Dr. Oyun was able to prepare the researcher with some previous adolescent sexual health studies conducted in Mongolia.

Focus Groups

Focus groups were conducted with three stakeholders of the peer education program: HMIEC staff, teachers, and students. A multiple category focus group design was used to manage the three groups of stakeholders, as described in *Figure 5.1*. Six initial focus groups were conducted, referred to as consultation focus groups. After a peer education program was deemed appropriate and was implemented for one month, two

more focus groups, called evaluation focus groups, were conducted with the same students participants.

Category	# of participants	Consultation		Eval.
Students (boys)*	8	●	○	
Students (girls)*	8	●	○	
Teachers	8	●		
HMIEC Staff	8	●		
AFTER IMPLEMENTATION & PEER EDUCATOR TRAINING				
Peer Educators (School 20)*	8			■
Peer Educators (School 58)*	8			■

*The students and peer educators are the same people.

- Culture of sexual health focus group
- Program design focus group
- Combined focus group (culture of sexual health and program design)
- Evaluation focus group that contributed to program design

Table 5.1. Multiple category design of the focus groups conducted in Ulaanbaatar, Mongolia Study

HMIEC Staff

The HMIEC staff that participated in the focus groups was selected on the basis of their current or past work experience related to adolescent sexual health and sexuality. All participants were Mongolian medical doctors. Their ages ranged from late twenties to late fifties. Three participants had reviewed the current sexual health curriculum in secondary schools and two participants were from the health promotion department. One participant sat on the STD/ HIV/AIDS information, education, and communication (IEC) committee and two had expertise in evaluation. Upon invitation of participation, staff received the information sheet. The consent form was provided and completed before the focus group discussion began.

School Selection

HMIEC has a Health Promotion department that is involved with the Health Promoting Schools that were mentioned in Chapter 2. Dr. Batnasan, who worked within this department, selected two secondary schools to participate in the study as he had working contacts with most school administrations within Ulaanbaatar and with some rural schools as well. Dr. Batnasan was not part of the research team but was an important informant. The most important criteria for a school being selected were the support and enthusiasm on behalf of the school administration for being involved in the program. Due to time and financial constraints, the researcher stipulated that the schools be in Ulaanbaatar. The schools selected were different in a few ways that provided some interesting comparisons.

School 20 was selected due to its enthusiastic school administration. This school was located in Central Ulaanbaatar and had over 3,000 students. This school was academically ranked second best within its district and the administration was very motivated to make the school stronger in other aspects as well. It had its own school doctor and a Red Cross hygiene program that involved peer trainers.

School 58 has had a successful relationship with HMIEC as a health promoting school, due in large part to a very co-operative and hardworking school director. As part of the health promoting initiative, this school has an accessible health room where health classes are taught and information from NGOs is displayed. This school is situated in the north-eastern part of the city where the city has been rapidly expanding. The infrastructure at this school was very poor as its attendance has double its capacity over a short period of time. To manage this increase in capacity, three shifts of classes are taught everyday from 8am to 7pm. A new addition was being built to accommodate its growing student population. The children at this school are poorer than School 20 and almost all of them live in the traditional *ger* with no running water. This school does not have a doctor on site.

Teachers

Dr. Oyun, Dr. Batnasan, and the researcher met the school administrations at each school to discuss the project design and selection processes for teachers and students. At both meetings, the biology teachers that taught health to secondary students were in attendance. It was at these meetings that the research team along with the school director decided which teachers would be selected. Each school was allowed to send four participants to the focus group. At School 20 there were three biology / health teachers that were identified as key stakeholders. With one person left, the research team decided to include the school doctor. Her duties included physical exams for secondary students (including pelvic exams) and general health promotion. All the IEC materials provided by NGOs were found on display in her office. She had also shown a lot of initiative with organizing the meetings between the research team and School 20.

At School 58, there were also only three biology / health teachers that needed to participate. With one seat left, the research team asked the school's social co-ordinator to participate as she was identified as a key organizer in the school. Although two of the eight participants of this focus group were not teachers, this focus group will still be referred to as the 'teacher focus group'. All participants were women ranging from mid twenties to late forties (N.B., most of the teachers in the schools were women does not appear to be a limitation of the study). Information sheets were given to the people at the selection meeting with the reminder that their participation was strictly voluntary. Consent forms were given and completed on the day of the focus group.

Students / Peer Educators

The target age for this program was set at ages 15 to 17 which correspond to grades 8 and 9 in Mongolia². The younger students in grade 8 that were 14 years old were allowed to participate. An assembly for grade 8 and 9 students was held at each school to begin the student selection process. Dr. Oyun and the researcher presented the concept of peer education, the objectives of the program, and the outline in Mongolian. It was

² Students begin school at age 7 in Mongolia and graduate after completing grade 9 or 10, depending on whether they intend to attend a post-secondary institution.

explained that the selected students would participate in consultative focus group interviews regarding sexual health and be trained as peer educators. The presentations ranged from 30 minutes to an hour, depending on the amount of translation done and questions asked. Afterward, interested students were asked to stay behind to take an information sheet and voice any questions or concerns. The researcher asked the students to think about the peer education program and prepare for a brief interview that was held two days after the assembly.

The number of students that showed interest in the program overwhelmed the research team. Over eighty people received an information sheet at School 20 and thirty-five at School 58. To manage the number of students, the research team solicited the help of Dr. Batnasan, who was very familiar with the project, to help with the student selection process. Each student had a five-minute private interview by Dr. Oyun or Dr. Batnasan. The students were asked: *“Why do you think you are comfortable talking about sexual health issues like STDs, condoms, and communication”* and, *“Why is a sexual health peer education program important for your school?”* The interviewers rated the students on their communication, listening, and comfort level with sexual topics using a pre-made form. In addition, any special traits that stood out about the student such as sincerity, enthusiasm, good people skills, humour, or leadership were noted. At the time of the interview, questions were answered then consent forms were explained again and then signed before the researcher.

Afterward, the interview form was matched with the consent form and the researcher and interviewers proceeded to select students using the scores on the form with other selection criteria such as special talents, diversity, age, and gender. Four students from each grade at each school were selected for a total of sixteen students, with an equal split of boys and girls. Students were contacted by phone and or through the school administration regarding their acceptance and the date of the first focus group was given. Below is the grade and gender profile of the students selected to participate in the focus groups and peer education program:

	School 20		School 58	
	Grade 8	Grade 9	Grade 8	Grade 9
Male	3	1	1	3
Female	1	3	3	1

Table 5.2. Selected Student Gender and Grade Profile

The research team presented the list of selected students to the teachers after the teacher focus group interview. School 20's teachers were concerned that two students on the list would not be helpful as they "*go out late to parties and sometimes miss classes*". The interviewers gave these students very high scores and so the research team decided to keep them. The teachers felt that student selection was very important and choosing these people might affect the success of the program. The researcher agreed that the selection process is important and reiterated that the team set out to select a diverse group of people who were not necessarily 'smart' or 'teachers favourites', but that could interact well with peers and reach many different peer groups.

After the consultation focus groups were conducted, the students that participated in the focus groups were trained as peer educators. The research team worked closely with the students for a few weeks to develop and implement the *STDs and Condoms* lesson plan. Teachers, school administration, and the Ministry of Education approved this lesson plan. The peer educators held a number of activities in their school including the presentation of the lesson plan, question & answer periods, and World AIDS Day activities. One month after the program had been implemented, evaluation focus groups were conducted with the peer educator teams from each school.

The peer educators participated in one two-hour evaluation focus group to discuss their peers' perceptions of the program, program successes, areas for improvement, and their own personal development. In addition, peer educators discussed what skills and knowledge they have gained by participating in the program. Girls and boys participated in the evaluation focus group interview together but this time, the peer educators from Schools 20 and 58 were separated.

This focus group utilized a pyramid interview approach that asks specific questions and then expands to general questions. This approach is more useful for changing policy or programs that have already been implemented, such as the peer education program at this point, as it begins to address specific concerns and relates those concerns to goals of the program (Rothe, 1994). This focus group was not piloted but was reviewed for content and linguistic reliability by the research team, Dr. Batnasan, and the moderators. Each focus group had a moderator, observer, translator, and transcriber present and the same ground rules were used as before. The consent forms signed by the peer educators for the research phase focus groups were effective for the evaluation focus group as well. Participants were reminded that their participation was voluntary. The moderators and observers submitted focus group reports.

Set Up of Focus Groups

All focus groups were held in the conference rooms at HMIEC. Chairs for the moderator and participants were set up in a circular manner around a coffee table that served some refreshments. All focus groups were audio taped, with the recorder placed on a table right behind the moderator. Just behind and off to the side of the moderator sat the observer and translator. The observer's role is to take note of group dynamics, participation, and behaviours. The researcher was the observer in all but the male focus group interviews and needed someone to translate simultaneously to her. Dr. Batnasan served as the observer in the male focus groups. The transcriber of the interview sat in the back of the room, taking notes on the focus group to facilitate her transcriptions. A white board in the room displayed the focus group ground rules. Those ground rules included the right to pass, respect others' opinions, only one person speak at a time, agree to disagree in the discussion, respect the confidentiality of personal information, and all questions are acceptable.

Because sex and sexual health are taboo topics in Mongolia, the moderators were careful to review the confidentiality issue with the participants once more, to re-enforce the ground rules, and to use "icebreaking" exercises before or during the interview. All

focus groups meetings were two hours long, including the icebreaking and other preparatory activities.

Trustworthiness of Data Collected

“Focus group research is scientific research because it is a process of disciplined inquiry that is systematic and verifiable” (Krueger & Casey, 2000, p. 198). Focus groups are a scientific method of data collection as their design is determined by the purpose of the study; establishing checks of ‘trustworthiness’ at every step of planning, data collection, and analysis. The goal of human research is to generate data that is an accurate reflection of how the participants thought and felt, which Krueger and Casey (2000) call “trustworthy data”. Data generated from focus groups are made trustworthy through good practice, which is systematic to reduce researcher bias (or maximizing neutrality) and provide continuous verification.

For the present study, researcher bias during data collection was kept to a minimum as she worked with a research team of moderators, transcribers, and translators that were Mongolian. This team was trained by the researcher to understand the research questions and their rationale so that all questions and probes asked during the focus groups were answering the research questions. After the focus groups, the research team debriefed with each other about the successes and limitations of each focus group. Also, the moderator and observer each submitted a report for each focus group so that the impressions and observations of the team were not forgotten. Agreement on the focus groups was made between the observer and the moderator when the individual reports were incorporated into one report.

Many checks were incorporated into the study design to ensure that the results are an accurate reflection of how the participants felt and thought about sexual health in Mongolia and peer education program design, thereby enhancing the trustworthiness of the data collected. First, the question guide was pilot tested once to verify the quality of the translation and to ensure that the language used made the questions understandable to the participant. Every focus group began with establishing ground rules to reinforce confidentiality of the discussion among the participants to provide a safe place to discuss

personal opinions. Participation was encouraged through icebreaker exercises to get everyone comfortable with each other. Appropriate selection of the moderator allowed the participants to feel at ease with the discussion and a trained and practiced moderator made the focus group flow smoothly. Also, the moderators were encouraged to seek participant clarification of answers and meanings.

Finally, the data was made more credible by the multi-category design of the focus groups. Interviewing three different stakeholders who had different perspectives on the same topic provided more comprehensive answers to the research questions (Cutcliffe & McKenna, 1999). Being able to compare stakeholder discussions highlighted some universal themes and some unique perspectives.

Translation

Every transcribed focus group discussion and moderator and observer reports were submitted to the researcher in Mongolian. Excellent translation skills were scarce in Mongolia and discrepancies between Mongolian to English translations made transcripts difficult to read (i.e., mostly due to the English vocabulary of the translator). To circumvent this problem, Dr. Oyun verbally translated the transcribed focus groups and reports to the researcher, who would type the English version on the computer. This method allowed the researcher to immediately clarify any terms with Dr. Oyun to ensure that words used in the English transcripts would most closely match the intended Mongolian meaning. This process made the researcher quite confident in trustworthiness of the data. The researcher was also able to simultaneously clean the translated focus groups into an easily readable script. The first male student focus group was translated by another person and did not undergo this same simultaneous feedback process. Some terms in this focus group should have been clarified with the researcher to shed more light on the meanings but overall, this focus group was insightful.

Method of Analysis

The method of focus group analysis can also add to the trustworthiness of the data presented. Cutcliffe and McKenna (1999) present guidelines to making the method of analysis that will maximize the trustworthiness of the data: auditability, verification, and applicability.

Audit Trail

Altheide & Johnson (1994) suggest explicitly outlining the pathway of analysis decision so that another researcher may check the method of analysis. This ‘audit trail is described below, using the example of embarrassment, one theme that was elucidated from the focus groups.

Every focus group was read through once. Jot notes about each sentence were made in the right margin to ensure that the meaning of each sentence was understood and that thoughts that were unrelated to the general conversation were not overlooked. Reoccurring words were underlined (e.g., embarrassment occurred many times in all focus groups). Text and jot notes were read through again and ‘codes’ were written in the left margin. Codes were generated by closely related or repeating ideas, comments or obvious symbols (e.g., talking openly and freely, a comment that was mention a few times is, the absence of embarrassment and was coded as ‘Embarrassment’). These codes were then grouped into broader themes that were still related to each other (e.g., any comments that had to do with embarrassment and communication such as embarrassment, secrets, shame, and talking openly and freely were all organized under the theme “Embarrassment”). These themes were written on note cards. Factors that contributed to theme development were frequency, specificity, emotion, and extensiveness of comments (Krueger & Casey, 2000). For example, embarrassment was mentioned many times and became an obvious theme. Homosexuality, on the other hand, did not have an extensive discussion, but the emotion that a small amount of discussion generated was great. Themes based on emotion were verified with the observer reports.

These themes were then transferred to a computer with all supporting quotations. The themes were sometimes reduced to sub-themes to understand them better. This was

not necessary for embarrassment, however, there were two issues related to homosexuality: anal sex and homosexuality not being native to Mongolia. Further, the researcher tried to explain the themes by asking the following questions of each theme:

- 1) How was this phenomenon constructed? (e.g., how did Mongolians make sex an embarrassing topic?)
- 2) What is the routine, behaviour, attitude or norm? (e.g., is embarrassment a common occurrence when talking about sex?)
- 3) How is personal meaning assigned to the phenomenon? (What does it mean when someone gets embarrassed?)
- 4) What is the purpose or intent behind this phenomenon? (Why did someone want to make talking about sex embarrassing or difficult?)

To view all the emerged themes together, a theme diagram was generated for each focus group, and was displayed together to aid theme synthesis (Krueger & Casey, 2000). After the above questions were asked, explanations and patterns of thought between and among themes of the focus groups became clearer, illustrated in the diagrams with arrows drawn to other themes. Also, common and unique themes among all the stakeholders stood out. Embarrassment was a theme or a sub-theme in every consultative focus group.

After synthesis of themes (and sub-themes), two theme diagrams emerged, each addressing a research objective. Themes related to the socio-cultural context of sexual health in Mongolia were much more detailed than the peer education program design. Again, the relationships between themes for each research objective theme diagram were drawn for more synthesis. Published data from Mongolian government and non-government organizations and research in China and Russia was used to explain the themes in addition to the researcher's own observations within Mongolia. For example, it became obvious that embarrassment was a result of traditional values in an effort to control sexuality and so embarrassment became part of a large group of themes that seemed to be related to traditional values (see *Figure 6.1*).

Verification

The data analysis should be verifiable. This means another researcher arrives at similar conclusions using an audit trail strategy, to ensure that primary researcher did not employ selected bias. Cutcliffe and McKenna (1999) caution that the primary researcher's familiarity with the data and the participants by working through every stage of the study will affect her interpretation of the findings. However, Casey and Krueger (2000) argue that consistent involvement of the primary researcher will only make the analysis more verifiable. The female consultation focus group on sexual health was given to another researcher (Canadian) with a written account of the audit trail that the primary researcher used her to verify the themes that she found. Similar themes were identified (i.e., they may have had a different title but the meaning and content were very similar).

Applicability

The most useful indicator of the credibility of the findings might be its applicability to the community or the meaningfulness of the results to new theories (Cutcliffe & McKenna, 1999; Krueger & Casey, 2000; Hills, 2000). Indeed, results from these focus groups will contribute to a list of recommendations for the peer education program that was developed. These recommendations should be deemed applicable by the participants of the focus groups (and stakeholders of the peer education program) although it is not expected that all stakeholders will agree on all recommendations, as the recommendations were derived from focus groups with different stakeholders with (sometimes) differing perspectives.

This study also provides a description of socio-cultural context of sexual health in Mongolia. The applicability of these findings for other NGOs in Mongolia must be determined by those people who plan to use this data, assessing the transferability of the research design, sample, and setting.

Limitations & Concerns

For participating in the research, all focus group participants were given 2,000 MNT (\approx 2USD) at the end of each discussion. This sum was deemed appropriate and used by MSF in similar circumstances. In relative terms, this was a substantial amount of money to be given. The researcher was concerned that this reward may coerce people into participating in the focus group. To minimize coercion, participants were told at the time of selection that they would receive a money gift but the amount was not disclosed. Participation appeared to be active and voluntary (i.e., some students could not make it to one of the focus groups and were not concerned that they did not get any money) so one can speculate that the gift of money did not affect the study.

There is also a negative group effect in focus groups, where participants may try to be the 'good subject' by censoring or conforming their comments according to their perceived role of the group (Asbury, 1995). When talking about sex, the participants may have reported behaviour that is consistent with gender roles and other expectations rather than their own behaviours and attitudes (Ip, Chau, Chang, and Lui, 2001). However, since the objective of this study was to determine the cultural environment of sexual health, self-reported bias may actually reveal more about those gender roles and norms.

Asbury (1995) caution that "social loafing" may also occur where some participants do not contribute to the discussion as frequently as others. In the first focus groups, a few students were noted as not being active throughout the discussion. The students may have disagreed, agreed but had nothing else to add to the discussion, or felt shy and uncomfortable about the topic. This observation was made and the moderators actively encouraged more discussion from these participants by individual probing. Of more concern were those participants that were 'over active'. It was difficult for the moderators to discretely minimize their participation, especially when they usually had something very interesting to say. These participants appeared to be very outgoing, articulate, and appeared to have a good sense of self-worth. Their opinions may be over represented in the focus groups giving an overly 'positive' sense of the sexual context. However, all views were presented in the findings, so this effect would have been

minimized. It does however bring to attention how homogeneous adolescents can be (discussed further in Chapter 7).

Employing two translators highlighted a limitation of the translation process. The words translated in the focus groups may not be the exact words of the participants but ‘words of best fit’ deemed appropriate by the translator which is dependent on the translator’s own vocabulary. For example, Dr. Oyun would always use the word ‘embarrassed’ when the other translator would use ‘feel shame’. In most cases, this probably did not limit the data at all. However, the researcher suspects that better descriptions of sexual terms noted by the male students would have been more enlightening if Dr. Oyun had verbally translated them to the researcher. Also, the translator may have used politically correct words like ‘commercial sex worker’ or ‘partner’ when the students were likely to use slang terms. In retrospect, this is a limitation of the data collected as slang words for ‘girlfriend’ or commercial sex worker could have highlighted some power imbalances.

While a broad range of topics regarding sexual health and program development were discussed, the researcher cannot guarantee that saturation was achieved among any of the participant categories (HMIIEC staff, teachers, and students). In the case of the teachers and HMIIEC staff, there were only a limited number of people who had related experience with teaching sexual health or being familiar with the school health curriculum that were identified as stakeholders of a peer education program that could participate. More focus groups with the students should have been conducted until the information shared at the focus groups became redundant. However, because the researcher was working in the field, resources limited the number of focus groups conducted.

Focus group interviews collect human experiences that cannot be generalized to a larger population (Kingry, et al., 1990). With this in mind, the participants of any focus group cannot be ‘representative’ of anyone except themselves. Therefore, the findings of this study or the views of any one stakeholder may not be representative of their school or the Mongolian adolescent population in general. The findings of this study may be transferable to other contexts, but its relevance must be judged by people in those

contexts (Hills, 2000). The findings of this study may be transferable to another location, but the situation, methods, procedures, and intended audience are all factors that need to be considered to determine their relevance (Krueger & Casey, 2000). Findings from this study should not be applied to other schools without the school administrations considering their own contexts and comparing them with the schools used here.

CHAPTER 6

Presentation of Results & Discussion

Introduction

The findings of the consultation focus groups (i.e., initial six focus groups) reflect how traditional values pervade many aspects of sexual health. Themes extracted from the focus groups such as embarrassment, normal sex, promiscuity and condoms, and gender roles appear to be expressions of traditional values (see *Figure 6.1*) and are barriers to sexual health practices. These findings also indicate that there is a significant link between drinking and sexual activity among youth that must be explored and addressed further. After exploring the culture of sexual health among youth in Mongolia, it becomes apparent that peer education is an appropriate intervention in the urban school context.

Culture of Sexual Health

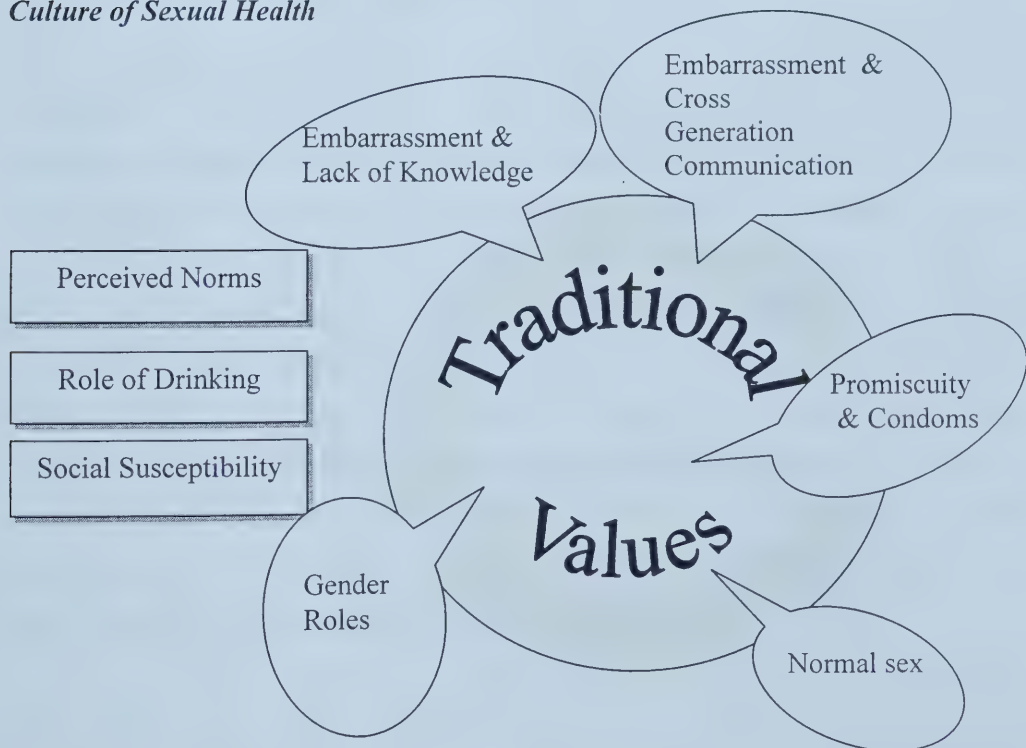


Figure 6.1 Socio-cultural aspects of sexual health that emerged from the focus groups.

Traditional Values

Traditional values were discussed indirectly in all of the focus groups although what it meant was never explicitly articulated. This was in part due to the fact that the Mongolian focus group moderators and participants were ‘insiders’ and already has a sense of what traditional values are so they did not address the subject of traditional values directly. Traditional values have become an overriding theme for most of what was elicited from the focus groups and appear to reinforce sex as a taboo topic.

Mongolians have existed as a distinct people for thousands of years, surviving empires, communism, and extreme weather. They built the greatest empire the world has ever seen, stretching from present day Hungary to Beijing (Greenway et al., 1997). Their harsh nomadic lifestyle has demanded an intimate relationship with the land and family, which is reflected in their culture and values. For the nomad, the family unit is his entire social network and business enterprise. It is within the tight family unit that traditional values may have played a very important role.

Mongolia’s great history has also seen some significant relationships with other countries and cultures that have contributed to Mongolian culture. For example, traditional Mongolian medicine is influenced greatly by its religion, Lamaist Buddhism, and therefore has roots in Indian, Tibetan, and Chinese medicine (Greenway et al., 1997). Over the past seventy years, Mongolia has also been greatly influence by the Soviet Union who introduced Mongolia to vodka, Cyrillic script, communism, and infrastructure to name a few items. Furthermore, certain cues within the focus groups indicated that there were similarities between Mongolian and Chinese views on sexuality as a taboo topic, possibly a result of China’s occupation of Mongolia from 1691 to 1911 (NSO et al., 1998; Zhang & Li, 1999). Because information on the culture of Mongolia is limited, the researcher referred to literature on Chinese traditional values to provide some insight into Mongolia’s traditional values regarding sex and sexuality.

Embarrassment

Embarrassment can be both psychologically and socially defined. All the participants discussed embarrassment several times, referring to that uncomfortable, red-cheek reaction (i.e., psychological) when they talk about something taboo or inappropriate. However, this embarrassing feeling is caused by the social construction of the topic of sex as taboo. Therefore, frequent mention of being embarrassed is the best indication of the extent of how taboo the topic of sex really is in Mongolia. As the focus groups reveal, the psychological definition of embarrassment is a major barrier to treatment, communication (but especially across generations), and education.

First, embarrassment is a barrier to treatment. In Mongolia, doctors are the primary and best source for sexual health information. However, their services are not without bias and embarrassment. Reproductive health services are generally gynaecological in nature, thereby neglecting male and adolescent needs (UNFPA, 2000). Males and adolescents are not able to visit a general practitioner, as not many exist, a result of the highly specialized, socialist health system. Confidentiality of the patient is not guaranteed and the doctors may blame the patient for getting the infection. A person with an STD may have to stay in a maternity ward or be transferred to the infectious disease hospital that has a specific ward for STDs, a very embarrassing and stigmatizing experience. For all of the above reasons, people will defer treatment or attempt self-treatment for a STD with over the counter antibiotics without the advice of a doctor (UNFPA, 2000). One female student said this:

“People that are infected with an STD will not go to the doctor to get treated because of embarrassment. That person could transfer the disease to others.”

Although doctors are considered to be the most knowledgeable about sexual health, for adolescents, accessing their help, discussing sexual matters directly, and ensuring confidentiality can be difficult.

“If we are not embarrassed, the most accurate source [for information] is doctors.”

“The hotline is the best [source for information] because sometimes when you see the doctor you are not comfortable asking questions. When you talk on the phone you can feel free.”

“If someone will go intentionally and subtly to find information, they can get it but most children are not confident and have some difficulty.”

There is a general awareness among all of the focus group participants that traditional values make discussing sexual matters difficult. One participant from HMIEC said, “We realize that reproductive health topics are sensitive which are related to our cultural attitudes which need to change.” Discussing sex with anyone has the potential to be embarrassing, however, talking about it among peers is the easiest. To avoid embarrassment, even peers use indirect language.

“We talk about sex more openly and freely [among peers].”

“We usually get embarrassed when we say ‘sleep with someone’ or ‘have sex’. It is more understandable to say ‘I have done it’ which means I have had sex.”
(Female Student)

Cross Generation Communication

Everyone is fascinated with the topic of sexual health, as one HMIEC staff member pointed out:

“HMIEC did a questionnaire with teachers, parents, and students asking them what was the most difficult and interesting topics are. They all responded on both questions ‘Reproductive Health’.”

However, Mongolian traditional values discourage cross-generation communication, making discussion about sexual matters between student-parent and student-teacher embarrassing. For example, adults with traditional values will often not share sexual health information with children, especially girls, in an effort to protect them from the temptation of sex. In addition, recent changes in society have increased the amount of sexual health information and education available, thereby creating a knowledge gap between adults and young people that make broaching the topic of sex even more difficult. Furthermore, embarrassment may become a barrier in learning about sexual health from adults.

The participants of this study suggest that parents do not discuss sexual matters, let alone puberty with their children or menstruation with their daughters. Most female participants reported they were unprepared for their first mense. Kids who are curious

about sex are thought to be sexually experienced, or as one girl put it, “my parents were suspicious of me”. Although talking about sex with a parent is difficult, the female students thought it is easier to talk about it with mothers.

“Since they were small, kids do not talk openly with their parents because they get embarrassed and cannot talk even now.”

“When I asked my mom about contraception methods, she doesn’t tell me. She says, ‘when you grow up you will know. Don’t be in a hurry’.”

One HMIEC staff pointed out that communication between parent and child may differ regionally; women in rural locales may adhere to traditional values more than the urban mother.

“It is easier for a city mother to talk about these issues than a rural mother.”

HMIEC staff recognizes how difficult teaching sexual health to young people can be and sympathize with schoolteachers:

“The results of a study showed that reproductive health was embarrassing. People were shy to ask questions and also some students were shy to ask questions from the teachers.”

“Even the best teacher cannot teach the students about sex.”

They [students] say, ‘Because the teacher is not a health professional, it is embarrassing to ask questions, even when we have a lot of questions to ask’.”

The teacher participants agreed that discussing sexual health matters with students is uncomfortable and challenging. They admit that topics such as love relationships, abstinence, and circumstances where students should not have sex are difficult for teachers to teach and they will try to avoid those topics. Teachers prefer to teach those straight forward topics with a biological focus such as fertilization, hygiene, and anatomy which have made up most of the previous curriculum and explain why it is biology teachers that teach the subject. Teachers agree that traditional values are a barrier to sexual health communication and education.

“The parents will say to the children just as we do, ‘You should graduate from school successfully’, they never talk about safer sex.”

“Teachers can’t talk openly to the students about sexual health because of our traditions and cultural attitudes.”

“We never recommend condoms or show them how to use a condom which proves there are barriers between teachers and students.”

Finally, the teachers are aware that students are getting a lot of information from the media and from each other and recognize the practicality of peer education. One teacher said, “The relationship between teacher and student is different from the relationship between students.”

Lack of Knowledge as a Barrier

The focus groups reveal that there was both a lack of sexual health knowledge and embarrassment among administrators, teachers, and parents that contribute to the knowledge gaps that exist among Mongolia’s young people. Embarrassment can create a lack of knowledge (by not communicating), however, a lack of knowledge can also perpetuate embarrassment, creating a vicious cycle. For example, participants discussed how administrators and teachers are inadequately educated on sex and sexuality and therefore, are embarrassed to impart comprehensive sexual health information to their students.

Health care in Mongolia was greatly influenced by Soviet central planning models where there were a high number of specialized physicians and compartmentalized departments (Government of Mongolia & UN, 1999). Due to this design, doctors appear to be the gatekeepers of health information, being perceived as the only ones competent enough to understand it and impart it to others. The presence of an on-site doctor at School 20, rather than a nurse or well-trained teacher verifies this view.

The topic of general health has not been made a priority issue within the Ministry of Education. It has never been taught to teachers at the university level. One explanation for this might be that teaching any health topic was restricted to health care professionals. During the HMIEC focus group, participants revisited old debates about who teach the new sexual health curriculum. The HMIEC staff recognize that teachers are not formally trained in the area, and some suggested that, to circumvent this, every school should have a doctor. However, the group came to the consensus that using doctors to teach health topics is impractical and that everyone should have basic knowledge on the subject.

“Topics on fertilization and ovulation should be taught by professional people because these topics are too complicated.”

“With exception to sexual health, all other health topics should be taught by doctors.”

“It is very old fashioned when the doctors should teach health topics.”

“It has been suggested to include family doctors in these activities but occasional teachers would not be helpful.”

Generally, the researcher observed that most Mongolians are proud of how the integrity of the school system was maintained through a very difficult political and economic decade while facing a population boom among young people with half of the population under the age of 20 (Patel & Amarsanaa, 2000). The basic subjects in the school system are in tact. UNFPA has been working with the Ministry of Health to make sexual health more of a priority, and to that end, a new comprehensive sexual health curriculum has been developed. Unfortunately, it has not been fully implemented, due, in part, to the lack of will of the school administration and schoolteachers and their own personal discomfort with the topic. Generally speaking, the older they are, the more they are likely to cling to the traditional values and not recognize some of the modern challenges and views. The teachers suggested that inefficiencies, limited class hours, and lack of priority all contribute to improper implementation of the sexual health curriculum.

“According to the curriculum, the assigned lesson hours for higher grades are not sufficient.”

When training the students to be peer educators, the research team found that there were differences between classes available at Schools 20 and 58 and knowledge levels of the students. Teachers find that their students also have varying levels of knowledge (depended on where they attended school before), therefore, making the curriculum difficult to execute. Failing to provide comprehensive sexual health education is not just a phenomenon that exists in Mongolia; it is a worldwide issue. Homosexuality and safer sex topics were the topics most frequently omitted from sexuality education in the United States as a result of real or perceived pressure from parents, administrators or community and inadequate knowledge (Remafedi, 1993). The HMIEC staff had this to say about teachers:

“The curriculum is late for implementation because ... the teachers are not trained on health.”

“Some of the teachers did not teach all the topics outlined in the curriculum. This was due to teacher methodology, knowledge, and skills on certain topics.”

One HMIEC staff person brought up an existing argument for limited class hours, citing that most sexual health education is done through informal means such as the family, media, and friends. They identified the family as the primary structure within Mongolian society, where the most health education takes place and that parents should be part of the educational process. However, such statements neglect the fact that the general adult population is not adequately educated about sexual health matters, especially modern contraceptives and HIV. Despite the deficiencies of sexual health curriculum, more information about sexual health and contraception is available in Mongolia than ever before. One must remember that most of Mongolia's adults grew up in a closed society, where pro-natalist policies pervaded the political and health systems. One HMIEC staff member recognized this and said, “Parents and family members should be taught reproductive health issues, too.” The informal education argument also does not consider that the media needs to be balanced with reliable information and decision-making skills. To use this argument to justify restricted funding and allotted lesson hours at school are impractical and perpetuate the barriers to knowledge.

As a result of parents and teachers being poorly educated on sexual health themselves and an influx of western media that is very open about the subject, young people are keen for sexual health information. Melburn (1995) reports that young people from a wide range of contexts believe that sex education in the school is inadequate. In the present study, all the teachers agreed that students want to learn more, especially current and relevant information.

“Some teachers think that this curriculum is not enough because students from grade 9 and 10 already have a lot of information and so they demand a lot of current information.”

“Yes, students know about STDs, but they would like to learn more.”

Most of the student participants said that they obtain most of their sexual health information outside of the school, realizing that not all of this information is accurate.

Common sources of sexual health information come from friends, newspapers, the Adolescent Future Centre (AFC) Hotline, and television programs. The most reliable sources of information were television shows developed by the MOHSW and the AFC Hotline. Newspapers were thought to be the most sensational.

“There is difficulty getting information that corresponds to each other.”

“The disadvantage of asking friends is we may have the wrong information.”

The disparity of knowledge between the girls and boys participating in the focus groups was very noticeable. The girls tended to have attitudes that aligned with their teachers about the susceptibility of the country to STDs and HIV/AIDS and pregnancy. The girls had a better understanding about different STDs. In contrast, safer sex messages are not getting through to adolescent males. The boys were less knowledgeable about AIDS and did not think they were susceptible if they did not have sex with commercial sex workers. They also seemed to hold a lot more myths about STDs and condoms even though they knew a lot about them. When asked about how serious STDs including HIV/AIDS are in Mongolia, the male students replied:

“I heard about it in reproductive health lesson, but do not know well.”

“Only two people have been infected with HIV. As for the others, they think that they are healthy so they don’t care about AIDS. Also the IEC [information / education / communication] activity is not so good.”

Finally, teachers realize that there is a gap between knowledge and behaviour. Education in Mongolia is based on knowledge rather than practical skills and usually utilizes lectures rather than interactive mediums or real life problem solving. The teachers commented that the students have knowledge on STDs but do not have the practical knowledge or experience. This is evident in myths that perpetuate negative opinions about condoms. For example:

“Knowledge or understanding on condom use is inadequate, so they don’t use them correctly.”

Normal Sex

The teachers and male had very candid discussions about what ‘normal sexual activity’ was. Homosexuality was discussed as an abnormal activity and ignited a very heated debate about the appropriateness of education about homosexuality.

The boys defined normal sex as vaginal penetration. However, some of the words used to describe vaginal penetration were very vivid. Fish play, to negotiate, to scrape, the function of cloud and rain, to get something from each other, to inflict, to sleep were all terms used to describe vaginal sex. Central to Traditional Chinese Medicine is the concept that the opposing forces of yin and yang exist in the universe in balance (Beinfeld & Korngold, 1991). Sexual intercourse is thought to embody the interaction of yin and yang and is often illustrated through elements in the environment. ‘The function of cloud and rain’ that the male students referred to is a term that has been represented in Chinese literature for thousands of years, where the cloud is the ovum of the earth and the rain is the sperm of the sky (Zhang & Li, 1999).

During 17th century China, “homosexuality and masturbation were condemned as forms of extramarital sexuality because they were non-procreative acts” (Dikotter, 1995, p. 138-9). As a non-procreative activity, homosexuality wasted sperm, “a man’s most precious contribution to the nation” (Dikotter, 1995, p. 171). By this definition, deviant sexual behaviour would include any activity that was not procreative such as protected, oral, or anal sex.

When the researcher was training the focus group moderators, she asked that they be explicit about what they mean by sex and clarify what the participants include in their definition of sex. The moderators’ speculated that the students would probably not know what oral and anal sex is as it is very uncommon in Mongolia. Ironically, there was debate among the boys as to whether oral sex is a common activity. Some thought that it is more common among prostitutes; some thought that ordinary people might also engage in oral sex, while a few boys did not think it existed at all in Mongolia at all. Interestingly enough, the boys used a Mongolian word to describe ‘sex with tongue’ that cannot be translated into English. It is likely that the male students learned about these ‘abnormal’ activities from pornography. In fact, the researcher found a discarded pornographic

newspaper on the street displaying a woman performing fellatio. A Mongolian newspaper article in the UB Post discussed how the government was considered imposing censorship laws that would rid their country of the considerable amount of pornography available (personal notes).

The boys also identified anal penetration as a form of intercourse. Two boys speculated that anal sex might be a common activity. However, others disagreed, suggesting that it is deviant behaviour and that it was associated with homosexuality. They had also heard about lesbians but were unsure of what activities they may do. Here is what the boys had to say about homosexuality:

“I think it is an abnormal thing for people to do.”

“I think that the people that seduce small children, they do it.”

“The homosexual people are very rare like daystar, we don’t know if it happens among our teens.”

The younger teachers also debated with older teachers whether homosexuality was ‘normal’ or not. All teachers felt that homosexuality was not an issue native to Mongolia; however, the difference was the younger teachers were prepared to embrace a ‘foreign concept’. Most of them felt very strongly that a teacher or a peer educator should not be teaching homosexuality, as it is an uncomfortable topic for them. None of the teachers considered that a student of theirs might be homosexual.

“Because homosexuality is a recent issue, even adults don’t know whether it is ok.”

“But it is a normal fact of life and it is likely that some students have heard about it and it should not be embarrassing.”

Promiscuity & Condoms

The focus groups revealed pre- and extra-marital sex and wasted sperm is discouraged, thereby, equating the purpose of using a condom with promiscuity. This perception becomes a barrier to safer sex practices.

There is one brand of condom, called ‘Trust’, which is endorsed by the MOHSW and NGOs. This brand of condom was available at most pharmacies and convenience stores in Ulaanbaatar while the researcher was there. Condoms cost 100 MNT (approximately USD 0.10) each, a cost deemed by HMIEC staff and students to be rather affordable. Availability is reported to be best within Ulaanbaatar, but occasionally shortages still occur. Discussions with the research team indicated that condoms have been in Mongolia for at least two generations but availability was varied.

For the most part, the perceptions of condoms were quite negative among all stakeholders despite condom endorsing campaigns by NGOs and health promoting television programs provided by the MOHSW. The researcher believes that all the stakeholders agree with the need for condom use for the prevention of STDs on an intellectual level, but those concepts were not internalized to a personal or practical level. This became clear as the suggestion of youth using or promoting condoms provided strong reactions, mostly centred around concerns for promiscuity. Negative perceptions of condoms also varied greatly with age.

Focus groups with the adult participants were especially lively as they conveyed the message that using or promoting condoms promotes promiscuity. One HMIEC staff referred to a survey that identified the perception of condoms and promiscuity as a barrier to safer sex practice.

“The result of one survey showed that young people refuse to use condoms because suggesting the use of condoms implies promiscuity.”

When asked whether the peer educators should distribute condoms, all HMIEC staff but one flatly rejected the idea saying that it is not appropriate. The other person suggested that condoms could be distributed only at the students’ request. Another participant commented that condom distribution may be embarrassing, although she did not state who it would be embarrassing for: the peer educator or the student. The reason for their rejecting condom promotion was articulated best by one staff member and was supported by everyone present, as no one disputed it.

“Condom distribution is completely wrong because when you do it you are saying, ‘use this condom, have sex.’ We never offer a toothbrush or toothpaste to someone when we tell them to clean their teeth. Same with condoms.”

Most teachers also rejected the idea of condom distribution. One teacher thought that condom distribution would be appropriate for grades 9 and 10 but not grade 6 or 7. Condom distribution was not discussed for grade 8, a target grade for the program. Again, the issues of promiscuity and embarrassment came up:

“[Distributing condoms] is embarrassing for university students so it will be embarrassing for them.”

“Nobody will take the condoms.”

“It will push students to have sex.”

The consensus between teacher and HMIEC participants was that it is not appropriate to distribute condoms but that the peer educators should teach how to use condoms correctly with a condom demonstration.

Most male and female students felt that they could distribute condoms at appropriate times such as during a presentation or discussion about condoms. One female student felt that distributing condoms would push the students to have sex. One male student was concerned that the students would waste condoms by playing with them.

“We would feel uncomfortable distributing condoms in our schools, during break time, or in class but we could distribute condoms as a demonstration in the presentation.”

“It would be okay to distribute condoms while we are talking or presenting on the topic.”

“Condom distribution is wrong. When we distribute condoms, the students will misunderstand us.”

“If we distribute condoms in our school, the students won’t take them for their real use. They will just play with them and enjoy them.”

The female students knew condoms were the only way to prevent most STDs including HIV. A couple of girls said that they would be confident enough to offer to use a condom to their partner. Others stated that feeling comfortable enough to offer to use a condom depended on trust in the relationship and the characteristics of the boyfriend. One girl said, “Mostly females offer to use condoms in preventing STDs and pregnancy.”

However, when asked about which situations they would not use condoms, the girls listed: when a couple wants a baby, when a couple trusts each other and are monogamous, when the boy refuses, or when they cannot afford condoms. The girls cited condoms causing loss of sexual potential and premature ejaculation as major reasons why boys refuse to wear condoms.

“Mostly boys refuse to wear a condom when it is offered because they think girls are healthy.”

“[When we have sex for the first time], we don’t use a condom.”

“I assume that students have sex for the first time when they are drunk at some sort of celebration, like a birthday party for example. In this case, they do not use a condom.”

These comments clearly reveal the power imbalance between men and women in Mongolia. Holland et al., (1991, p. 130) assert that “using or not using a condom is not a simple, practical question about dealing rationally with risk; it is the negotiation between two potentially unequal partners”. A review of several studies in many countries including Nigeria and the Philippines found that even women who are aware of the risks of HIV and prevention measures, they did not have the power to ensure condoms are used (see MacPhail & Campbell, 2001). Men’s dominance over women, dislike for condoms, and the priority for their sexual pleasure can make negotiating condom use very difficult for women. Furthermore, condom use is a temporary behaviour that men often expect to be phased out in monogamous, trusting relationships as contraceptive concerns concentrate on only pregnancy (Holland et al., 1991).

From the male responses, it seemed as though they were quite knowledgeable about condoms but the prevailing negative attitudes and myths about condoms were major barriers to their use. They knew that condoms are convenient and affordable and cited “Trust” brand as the best condom. Some participants also knew to check the expiry date and package integrity before using.

“I think that proper condom use is the most appropriate [contraceptive] method.”

“The best method to prevent STDs is to use a condom.”

In the male participants' opinion, only one third of peers that that already had sex may try using a condom. However, Reilley et al. (1999) found that only 17% of single youth (aged 15 to 25) in Ulaanbaatar used a condom at their last intercourse. There are a lot of reasons not to use condoms for the boys, including perceived discomfort, lack of pleasure, embarrassment, and traditional notion of wasted sperm. Masculine concepts of men 'needing' sex and skin-to-skin contact are prevalent in many countries (MacPhail & Campbell, 2001). Here are some common disincentives that the male participants discussed:

"Some think that they might orgasm in it".

"They think that a condom will make you less excited and your penis will get bigger."

"When they first have intercourse they prefer to feel it for real, so they don't want to use a condom."

"[To use a condom], the partner must make a provoking impression."

Again, issues of embarrassment and promiscuity arise when a boy tries to negotiate condom use with a girlfriend. Doing so implies that either she has a bad reputation (i.e., not clean because she has had sex with other boys) or that he has been promiscuous or unfaithful.

"If girls wanted [a condom] themselves, it might be ok. Otherwise, it is very difficult and the girlfriend will misunderstand. For the girlfriend I can't, but to the others I can offer it. In fact, teenagers can talk about condoms without shame – we can talk openly, but when we use it is more of a problem."

Gender Roles

The focus group discussions about condom negotiating indicate that men have the majority of the power in relationships in Mongolia. Although condom campaigns seem to have reached the students that participated in the focus groups, condoms are not used as boys try to relate to notions of masculinity.

During the 17th century, the Chinese government enforced sexual chastity and conformity. Men were encouraged to be active while women were encouraged to be

sexually submissive and passive (Ip et. al, 2001). Gender roles also define one's reputation, which have socially important repercussions. Boys are supposed to have sexual experience and should talk as such. Girls are supposed to be inexperienced and not interested in the topic. Premarital sex is especially discouraged for girls.

A girl's 'good reputation' is maintained by not having sex and not talking about it as if she has had experience with it. A girl must maintain a clean reputation if a boy should be interested in her. The female students listed talking, doing homework, going to the cinema, or hanging out with friends as activities a couple would do together. When asked if girls with boyfriends kiss or touch each other, their response was very vague and casual.

"If a girl gets into a relationship with every boy that asks her, she gets a bad reputation. It is opposite for boys, if he goes with every girl that asks him, its ok."

"If they know you slept with someone, they will talk poorly of you."

The boys felt that it is their job to initiate sexual intercourse, as they are braver than girls. Having sexual experience and knowledge promotes a good reputation for boys: common expectations in masculine societies from all over the world (MacPhail & Campbell, 2001). Furthermore, boys are supposed to naturally know about sexual activity and initiation and can be stigmatized if they try to seek information. This was confirmed by the boys' conversations in the focus groups as they discussed their concerns about confidentiality when seeking sexual health information from anyone (e.g., doctors, teachers, friends) and their repeated questions about "what is involved in first sex" and "how to initiate first sex". Typical date activities for boys were drinking, camping, going to the cinema, visiting one's home, and having sex.

"Boys have to initiate intercourse because we are more brave than girls."

"The disadvantages of using friends as information sources are they may have the wrong information, also, sometimes it isn't so confidential."

MacPhail and Campbell (2001) discuss that the perception of being able to filter out dangerous or infected partners is a common notion among young people, but especially among men. In the present study, the male participants also felt that by ensuring that the girl he is with has a 'clean' reputation, he is protected from STDs. A

boy's reputation can be tarnished if he gets an STD. Perhaps the boys don't see the necessity of learning about how STDs are transmitted or how to use a condom because they use a girl's reputation as a means of protecting themselves.

"Boys think that a girl that they will sleep with is a virgin, so they hope that they will not get an infection."

"It depends on the particular person [if a condom should be offered]."

"Because getting STDs will blemish our dignity, we will have to go home from school and change the way we communicate with our friends and will look stupid for a long time if we don't get treatment. We will feel lonely."

Adhering to strict gender roles can put young people at risk for STDs and HIV, as women are not able to participate equally in the sexual decision-making process (Rivers & Aggleton, 2000). Masculinity in most cultures dictates that men should have multiple partners and have power over women, and have negative attitudes towards condoms. Indeed, having multiple partners and not wearing condoms because they don't like condoms or screening the 'dirty' women out put men at risk for STDs including HIV (MacPhail & Campbell, 2001). For women, having a 'virginal' or 'clean reputation' is also a social norm in patriarchal cultures. Putting high value on a clean reputation may put women at risk for rape, unwanted pregnancy, or STDs / HIV, too. Because of the need for a clean reputation, women cannot initiate a sexual encounter but must accept one on a man's terms. Such a position diminishes a women's ability to say no to sex, negotiate safer sex, or carry a condom (MacPhail & Campbell, 2001). The imbalance of sexual power becomes clear; men are in the position to initiate sex and have the last say about contraception. The boys' vocabulary for 'normal sex' with a girl such as to scrape, to inflict, to get something from each other were quite aggressive, further articulating this power imbalance.

The student participants had mixed ideas about contraceptive responsibility in relationships. Some female participants felt that contraception is a female responsibility as the burden of pregnancy falls on them while others felt that times had changed and that both girls and boys are responsible for not getting pregnant. A few boys felt that the responsibility should be shared and that division of responsibility depends on the couple's experience and knowledge. The remaining boys stated that contraception is the

responsibility of the girl. Consistent with this view was the fact that male participant discussions about condoms were always framed around STD prevention, not birth control. Contraception aside, the boys were clear that it was their role to initiate intercourse. Here is what the male participants had to say:

“Boys initiate intercourse but girls should have more responsibility because they get pregnant.”

The female participants were aware of the negative consequences that may result from unprotected sex. They discussed how having an unwanted pregnancy would have a negative impact on their future or on a future marriage. Parents are afraid of the burden (e.g. financial) that a teen pregnancy might bring to their house. Some girls said that if they got pregnant at their age, they would get an abortion despite their fears that an abortion might cause infertility. One girl said she would have a miscarriage over an abortion (presumably induced by herbs or acupuncture).

“They (parents) think that if you are in a relationship you will get pregnant. Some parents will say, ‘You’re in a relationship and soon you will get pregnant and bring your baby here’.”

“It would be difficult to raise a baby. A lot of difficult issues would come up.”

The girls named spreading STDs, infertility, premature or unhealthy babies, and infecting internal organs as consequences of being infected by an STD. Also, the financial burden of an STD is also a concern, as one girl stated, “Most STDs can be cured but this requires money.”

Peer Norms

Both male and female students guessed how many of their classmates have had intercourse. The grade 8 and 9 male participants estimates ranged from 20% to 80%. Two girls agreed that 70% of their classmates have had sex. In fact, Reilley et al. (1999) found that only 4% of Mongolians aged 15 and 29% of youth aged 17 have had sexual intercourse. The students may have overestimated how many students have had sex because of gossip and the secrecy that shrouds the subject. Accurate or not, believing that the majority of your classmates are sexually active will put pressure on you to have sex.

Reed and Weinberg (1984) proposed that all social groups are influenced by their peers, but adolescents are most sensitive as they begin to develop their sexuality and do not know what sexual behaviour is best for them. In most contexts, peer norms encourage unsafe sexual behaviour (MacPhail & Campbell, 2001). The female students listed some contradicting reasons for the high number that they reported:

“Society is too open now. Some students hide that they have had sex.”

“Usually when we talk with our friends, they have had sex.”

“Sometimes students compare themselves with foreign students on TV. We know that in developed countries, the students have sex for the first time at 12 or 13. So when we compare with them, we think that it is already time for us to have sex.”

“Having sex is a secret thing for everyone so we don’t often talk about this”.

Teachers on the other hand, estimated that somewhere between 2 to 12% of students in grades 8 and 9 have had sex (age 14 to 17). The teacher participants believed that most students that do not have problems in school would wait until after graduating from school to be involved in a sexual relationship. The teacher’s may have underestimated student sexual activity, as they may not realize the prevalence of drinking and sex among their students, especially if it is occasional and does not affect their performance at school.

There is a desire among young people in Mongolia to be modern according to Western standards in many different aspects including sexuality. When adults are clinging to traditional values, young people in Mongolia are seeking role models about how to behave in an open society and may turn to media from America and Europe where the cultures are much more sexually permissive.

Between traditional gender roles, the pressure of keeping a clean reputation, and being modern by meeting these perceived ‘western standards’ for first sex, and their own sexual feelings, these girls seem to be put in a conflicting situation where they don’t know how to act. Adding pressure is the fear of being ‘found out’ is because the schools in Mongolia have routine medical exams. One girl commented, “In our school, we have medical exams from the doctor. We are afraid of having a medical exam. We are also afraid of having sex. Therefore, I think 18 to 20 is a more suitable age.” MacPhail &

Campbell (2001) assert that these contradictions also occur in developing countries as well and that the need to adhere to these gender roles puts women's health at risk. For example, girls in Mongolia turn to drinking to manage this conflicted situation, putting their health at risk.

Role of Drinking

In Mongolia, drinking vodka is common and a sign of good hospitality, a custom adopted by the Russians in the 1970's. There is immense social pressure for men to drink to get drunk and alcoholism is an increasingly visible problem for Ulaanbaatar (Greenway et al., 1997). Bravery is intimately tied with drinking, as Chinggis Khan, the ultimate icon of bravery, is found on many vodka bottles. Drinking is an important 'coming of age' activity for males and plays a significant role for sexual activity among young people. The focus groups revealed that boys begin drinking in grades 6 and 7, a couple of years before girls. It seems that there is a lot more sexual activity when alcohol is involved. In the focus groups, the female students tended to avoid the topic of sexual activity and described innocent activities for dates. However, they estimated that up to 70% of their peers have had sex before and discussed how common it was for their peers to have sex when they are drunk.

The female participants discussed how the girls use alcohol to forget about the expectations that traditional values and gender roles put on them so that they may explore their own curiosities about sex by discussing it or trying new activities. As the girls disclosed to the researcher after a focus group, many girls fear that "a girl's first time" will hurt. Drinking may disinhibit them enough to overcome those fears. Lastly, drinking lessens a girl's ability to defend her to varying degrees and sex may be forced. The girls were aware that boys get girls drunk to have sex with them, but they did not call this action "rape".

The boys felt that drinking was an ordinary part of dates with girls. Alcohol serves to disinhibit boys' fears of rejection, making them "braver" to initiate interactions with a girl, negotiate sex, and possibly use protection. Here's what the male participants had to say:

“On a date, sometimes we get drunk.”

“At this time we negotiate to each other to have sex.”

“It is very common for kids to have sex when they are drunk.”

“Boys prefer to have sex when they are drunk.”

One boy discussed how drinking will make a girl flirt with boys or want to have sex. The male students also described techniques people use to get girls drunk faster such as adding vitamin E or red pepper to their vodka. The girls confirmed this behaviour and gave the impression that girls don't really want to have sex in those situations. These coercive actions are date rape, although the boys did not describe them as so. Rape is a criminal offence in Mongolia. In 1999, there were 23,352 reported offences, and 376 rape convictions (MOHSW & UNFPA, 2000).

“I heard that boys make girls drunk and after that they have intercourse with them.”

“If a girl refuses sex, the boy will get her drunk and she will get excited and then they have sex.”

Negotiating safer sex may also be very difficult for boys. One male participant suggested that being drunk might help him negotiate safer sex.

“It is difficult to use condoms when the lights are on and we are not drunk, but I think that I can use one when it is dark and drunk.”

Social Susceptibility

Both the teachers and female students articulated their concern for the social changes that are taking place in Mongolia and the effect that it has on young people. Both stakeholders believe that their society has become ‘too open’. The female students described how the social changes have made people susceptible to sexually transmitted diseases. The teachers believe that they have a role in controlling and protecting youth from these changes. The female participants assert that the social freedom is causing people to have sex at earlier ages.

“There are a lot of bars and night clubs right now. People are going to these often, especially young people.”

“Our peers should love each other as brothers and sisters, but right now boys and girls love each other as wife and husband. The current time is too open and free.”

The teachers cited increased alcoholism, family divorces, and unemployment as having a great effect on youth. The girls seem to believe that they are also vulnerable to the situation by being aware that a pregnancy or an STD would have a negative impact on their future, finances, health, and relationships. Finally, they believe that poverty is making their country susceptible to AIDS and that rural people are at the most risk. Rural youth, in their opinion, do not have access to condoms and contraception like urban people do and are more likely to drop out of school.

“If AIDS comes to a poor and developing country that is small, it will spread very quickly.”

“The spreading of AIDS is very high in developing countries because of commercial sex workers.”

“College and university students from the countryside don’t have money and can’t find work so they have sex for money. They are ready to get STDs.”

Furthermore, the girls think that the boys do not feel susceptible to AIDS or STDs because they perceive it as a problem confined to sex workers. In fact, the boys interviewed did not discuss their personal susceptibility to AIDS and stated that it is not much of a problem in Mongolia. MacPhail and Campbell (2001, p. 1619) state, “a requirement for translating knowledge into behaviour change is feeling personal vulnerability to HIV infection”.

“Especially boys don’t take this issue seriously. They say, ‘We never go to the commercial sex girls’.”

The teachers also see themselves as agents of social control during these turbulent times of shifting values and more exposure to the media. The teachers suggested that the majority of students do not have sex until they have completed school, believing that those who do have sex are more likely to be the problem students who party and miss class. In these cases, the teachers may discuss the problem with the students’ parents. They believe children that are more disconnected from the controls of teachers are more

susceptible and sensitive to the effects of social changes. Children not in school are most susceptible.

“The students who drop out of school or street kids have their first sex earlier than children in school.”

In addition, the teachers see themselves in the important position of correcting misinformation, recognizing that the students get a lot false information about sexual health from friends and unreliable media sources and that it is up to them to correct the students, through lessons in class and individual questions from students. Obviously, some teachers must be approachable on the topic of sexual health.

“The students listen to the information, even when it is inaccurate, which causes misunderstandings. Therefore, it is very important to provide correct sexual health information at school.”

Sometimes students get false information from each other and they come to us to find out what is correct.”

Peer Education Program

The results of the focus groups indicate that the peer education program does have an important role to play at Schools 20 and 58. There are a number of socio-cultural related reasons for implementing a peer education program including a lack of sexual health knowledge among the general population: a lack of cross-generation communication, and the prevalence of drinking among youth. The peer education program needs to educate students that are keen to learn more about sexual health and provide students with culturally appropriate risk reduction skills. For this section, consultation and evaluation focus groups were used to determine the program design, including presentation style, peer development, and support for a school-based, peer-led sexual health education program. During the consultation phase, the students selected to be peer educators participated in focus groups divided by gender. After training and program implementation, the same students, now peer educators, participated in the evaluation focus groups as a school team.

Purpose of Peer Education

The teachers mentioned that sexual health is taught in two different curriculums (i.e. reproductive health and family health), although there seemed to be some differences between the two schools. In fact, consistent implementation of the reproductive health curriculum by teachers and schools is a major problem for teachers and students. For teachers, it is difficult to teach the topic when their students have varying basic knowledge. Part of the challenge of implementing the curriculum is due to the insufficient number of lesson hours that is assigned to reproductive health.

“The existing curriculum is for grades 3 to 10... Basic knowledge is not given equally. Even though this curriculum is appropriate for those ages, in reality, it has not been implemented.”

“There is no time to teach all the information that the students ask for.”

A couple of the female students said that they had not had any lessons in sexual health yet. Generally, both the male and female students were interested in all the sexual health topics that the teachers addressed including STDs, contraception, anatomy, and

hygiene. Despite the fact that the boys' knowledge did not seem adequate and that the boys did not want their teachers to conduct the peer education training, two male students said that teachers did a good job of teaching condom use, contraception, friendships, and relationships. Perhaps they had one teacher that addressed these topics well. The boys were concerned that not all the students would participate in sexual health classes.

“During the health class, some students do not participate.”

The female students felt that it would be more understandable if their teachers used simple rather than technical words. The boys also wished that the teachers would provide handouts or other materials related to sexual health. Topics that were not taught by teachers but could be taught by the peer educators were: how to engage in a sexual relationship, how to prevent STD infection, and how to seek treatment if you are infected.

It became clear that the purpose of peer education is to supplement an overloaded health curriculum and clarify topics among peers that might be brought up in health class. HMIEC staff thought that the content of peer education program should supplement gaps in knowledge that is determined by the students. Also, the program should be targeted toward student social groups and networks where information flows easily. Students expressed the concern that the program needs to be relevant and accessible to reach as many students as possible.

After one month of presenting in their school and receiving feedback from their classmates, the peer educators from School 20 felt that the peer education program was very relevant to most of the students at their school. One peer educator cited teen pregnancies in their school as rationalization for the program. Some classmates ignored the peer educator activities because they were not ready for this information yet (i.e., they were not adults). The peer educators also received a lot of requests to present again and to other grades. The peer educators considered their school to be very fortunate to have the peer education program as their students would have a definite health advantage over other schools in Ulaanbaatar. Finally, the peer educators were confident their classmates understand now that they might be at risk of contracting an STD.

“In our school, there are two pregnant girls from grade 6.”

“Because we are peers, we understand each other easily.”

“Some of the classmates that attended our question and answer period or presentation asked when we would present again. Some asked, ‘is it possible to be a peer educator like you? How?’”

“...some of the students from other classes or grades asked us to present to them.”

“While we are conducting the question – answer period with our classmates, they think there are some STD infected students.”

Peer Development

The peer education team consisted of eight peer educators at each school (four peer educators in grade 8 and four in grade 9). HMIEC staff and teachers agreed that participation in the program should be voluntary and that peer educator selection was critical to the success of the program. The selected students should be leaders, friendly, open minded, and have good communication skills. One teacher suggested that their classmates should elect the peer educators. Both HMIEC staff and teachers thought that the program should select for younger students (grades 6 and 7) to improve peer educator retention as grade 9 is the last year of school for some students while others will go on to complete only one more grade. However, the study conducted by Reilley et al. (1999) suggested that age 15 was an appropriate age for sexual health education. Given this information, the researcher felt that it might be most relevant to implement a program for students age 15 to 17.

“If the leader is a teacher, they will make us feel uncomfortable and we have difficulties between teachers and us.”

The students recognized that if they were to be peer educators, that they must be knowledgeable themselves. Both the male and female participants thought that contraception and STDs should be included in peer educator training. Reflective of their gender roles, the boys were more concerned with the details of sexual intercourse, whereas, the girls wanted to learn about relationships, abstinence, and pregnancy options. Teachers wanted the peer educator training to include friendships, relationships, and communication skills.

“...sexual intercourse including first sex, what items should be focused on during first sex, STDs & consequences, and sexual hygiene.” (Male student).

“ ...detailed information on sexual health, friendships, relationships, ...harmfulness of miscarriage and abortion.” (Female student).

“We want the peer educator training to include STDs prevention and not to have sex at an early age.” (Female student)

The students thought that young health professionals with good teaching skills were the most qualified to teach at peer educator training because their lessons would be relevant, interactive, and accurate and they would be more approachable. They did not want their health teachers to train them. Boys and girls should participate in the lessons together. The students wanted to have interactive and multimedia lessons with video, role-playing, and posters. They felt that detailed and accurate information was important and having handouts would be helpful.

“Just lecturing is not interesting, [we need] good explanations and demonstrations with posters and pictures.”

The peer educators need to be rewarded for their work but financial rewards were not sustainable. HMIEC staff suggested that the peer educators could be rewarded through support, continuous education, and official recognition from the MOHSW. In fact, after training, the peer educators received a formal certificate of training from MOHSW. The students also thought that periodic workshops and meetings were good rewards. Other rewards were support and ownership oriented, such as consistent feedback, good support, and proper program identity.

“We don’t need money as a reward. We would rather get something unforgettable.”

“We are happy we are learning a lot. This is our reward.”

The peer educators from both schools were very grateful for the opportunity to participate in the program and make new friends between the School 20 and 58 peer educators. They began to realize the ‘ripple effect’ that their presentations may have in their school and felt helpful and easily understood. They thought that training had taught them a lot of new, relevant information as well as correcting misconceptions and providing clarification. Some peer educators admitted that although they had heard of

AIDS, they didn't really know what it meant until training. They also learned that there are a lot more STDs than they thought and how to prevent them. When it comes to sexual decision-making, they admitted that they didn't know what needed to be considered when thinking about sex and relationships. Now they do.

"I realize now that a person who thinks they have an STD should first see a doctor."

"Before we had the wrong idea about how to wear and store condoms. Some of us had never seen or touched a condom before. Now we know how to use condoms and where to keep them."

"For example, gonorrhoea is transmitted when you have sex in the cold. Now it is clear for us."

"Before training, we had a lot of misconceptions like when you use a condom, sexual potential will be reduced or you can't get pregnant the first time you have sex. These things have been clarified."

Being peer educators has affected other aspects of their lives as well. First, they are becoming more confident. A couple of peer educators were uncomfortable talking about sex and condoms publicly, especially if it was not to their homeroom class. A few were afraid of public speaking at first but most of the students reported that they were happy presenting. One peer educator said that she has begun to participate more by asking questions in other subjects at school. Everyone generally agrees that their new role at school will have a positive effect on their lives, including being more open with their partners about using condoms. Second, being a peer educator has affected relationships in their lives. They report that they are even closer with their old friends because they are communicating better. Another peer educator said he has quit using street words. They are meeting more people in their school and making new friends as well.

"I have talked about sexuality with my classmates before, but now I talk about it more."

"After our presentation, some of the students became closer to us."

"Even neighbour girls ask to get information from me."

Relationships with parents and teachers have changed too, some positively and some negatively.

“My parents are understanding me. Before they were always suspicious of me.”

“Sometimes my mom gets mad saying, “You go back to school everyday [to work on peer education activities].”

“We began to really understand our teachers’ difficulties.”

Presentation Style

Despite the fact that the students seemed satisfied with the reproductive health topics that their teachers taught, the topics that they thought they should teach as peer educators were very similar. The topic choices were also very similar to those discussed for peer educator training, including: STDs, contraception, hygiene, friendship, and relationships. Again, the boys wanted the topic of engaging in a sexual relationship included in the program. The girls repeated their suggestion of how to postpone sexual activity and added the topics of puberty, alcohol, tobacco, and the difference between love and friendship. Most HMIEC staff thought that the peer educators could teach all sexual health topics, although some thought those topics like fertilization and ovulation were too medical and technical. A male student suggested that the lessons should start out very basic and grow increasingly detailed.

The students were concerned about keeping the lessons interesting enough to keep their classmates’ attention and participation high. Just like peer educator training, the students suggested that their presentations be interactive and use more materials like videos and posters. The male students thought that discussion groups within the presentations might be easy. To reiterate, the students thought it would be appropriate to distribute condoms to their classmates during a presentation or related discussion. The peer educators enjoyed the icebreaker activities that were conducted before each focus group and felt that these games would also benefit their own presentations.

“Before our presentation starts, we should outline our lesson with funny stories and games like icebreaking in order to make the class active.”

Given how some of their classmates participate in health class, the students were most concerned about whether their classmates would listen to or disturb the presentations. Some felt that a teacher or a doctor should be present during their

presentation to keep the class in order. Having a doctor present could provide support and clarification and feedback if needed. Others felt that having an adult present, especially a teacher, would impede open class discussion.

“My main concern is how the students will receive us.”

“We will be embarrassed while teaching if a student says something rude or teases, like when we do a condom demonstration.”

Initial peer educator presentations were done in the presence of the research team, not a school doctor or teacher, to see what class behaviour and attention is like. Both the students and teachers agreed that the peer educators should present in teams of three or four so that they can help each other with class management and the presentation.

Despite these fears, the peer educators received a lot of positive feedback from their classmates during and after their presentation in the form of thanks and questions indicating that their presentation was indeed interesting and relevant. The peer educators felt very motivated and satisfied with this feedback.

“When we started to present, some of the students would ignore us or say some bad words. By the middle of the presentation, they realized the information was important to them and began to listen to us. They wanted to learn more from our presentation.”

“The students who bugged us before apologized and thanked us for the presentation afterward.”

“The best thing was when our classmates and friends started to ask questions that they are interested in or need to know.”

“My classmates have received my presentation very well. They say, ‘Now we have someone who can answer our questions.’”

“Even though we know that teachers are good at teaching and they have more knowledge, the students liked our presentation better.”

Although the peer educator presentations were received well by the majority of the students, some students did not participate by walking out, talking about something else, or ignoring the peer educators.

“It is very difficult for us when the students are not active in our presentation.”

“Some of the our classmates called us ‘AIDS educators’ or ‘sexual teachers’ or ‘AIDS kids’ but these names don’t bother us now because we are comfortable with these words.”

Based on these initial experiences and feedback from their classmates, the peer educators had some recommendations regarding the *STDs and Condoms* lesson plan and the expansion of the program in a few different ways.

STDs is a very complicated topic and a lot more time could have been invested at the training session for a broader understanding. Compared to the training sessions, the STD section was really simplified, perhaps too much and the peer educators felt that the modes of transmission needed to be more comprehensive. One peer educator was concerned that the lesson plan was confusing by describing common STD symptoms and then saying that most STDs do not present any symptoms. Also, simple words should be used.

“We should clarify STD symptoms because most students don’t understand that most STDs occur without symptoms.”

School 20 and 58 peer educators expressed concerns about when they made the formal presentations to their classmates. School 20 peer educators presented during health class lesson hour. If the peer educators were presenting to a class other than their homeroom, then they had to miss a lesson in another subject that was scheduled at the same time. Conversely, the School 58 peer educators presented to their classmates after school was finished for the day, which they believe, affected their peers’ attention and participation in the lessons. These are issues that the co-ordinator and school administrations are going to have to discuss again to find better ways to accommodate the presentations.

“After class, students want to go home. Therefore, we would like to have our presentation during class time.”

Despite some difficulties, the peer educators would like to see the program expand in the schools and in Mongolia. First, they mentioned that they would like to present the lesson plans to grades 7 and 10 as students from these grades have been requesting. Also, they would like to see more lesson plans included in the program, such

as contraception, as they believe that young girls are getting pregnant. Lastly, the peer educators think that more schools should be included in the program.

Support

All the stakeholders decided the program would be more sustainable if the program had a co-ordinator. The students to be trained as peer educators expressed their need to be open with the co-ordinator and therefore, this person should be a health professional instead of a teacher. One student thought that the co-ordinator could be an elected peer educator. But most felt that having a knowledgeable health professional would be most beneficial.

MacPhail and Campbell (1999) insist that health promotion interventions such as peer education be supported by many community organizations and actively participate in the research. The school is the primary community that the peer education program operates in and must remain supportive and active in it. Unfortunately, support for the peer educators and the program within the participating schools has been mixed. In general, the teachers that participated in the consultation focus group and the school directors have been very helpful. Other teachers in the school that may not understand the objectives of the program have not been supportive.

Both school directors were present for the opening ceremonies for the peer educator training session and met with them afterwards to discuss the training events, which really encouraged the peer educators.

“While organizing our activities for World AIDS Day, our director came to see what we were doing. We were very happy with that.”

“On World AIDS Day, we had an essay writing competition.”

“When I ask about something I don’t know very well, the health teacher explains very well.”

“They are polite and warm with us. We are supported by our biology, chemistry, and health teachers.”

However, teachers that were not directly involved in program planning have been unsupportive and critical indicating the need for the peer educators and the program objectives to be introduced to all teachers within each school.

“My homeroom teachers says, “You peer educators always meet with each other and do work other than homework. This might affect your academic standing.”

“Some of the teachers don’t help or support us. They think we are still small kids.”

“We want our teachers to really understand our activities.”

The peer educators from School 20 were very concerned about the waning support from their teachers.

“Our school doctor was supporting our activities and ideas in the beginning but this is decreasing.”

“The organization and management of activities is not good in our school. It is important to have teachers that manage well.”

During the consultation focus groups, the students determined that they needed to have support from the school administrations, their own visual identity with a logo and badges, and a room that they could conduct and plan their activities in. These items of support and ownership were perceived as sufficient rewards for themselves. Some of these requests were very practical. For example, School 58 peer educators had a difficult time conducting and planning activities as student ‘door keeps’ would not let the students back into the school after their classes were over. If, they had an official peer educator badge, it could act as a pass. Also, students who do not have peer educators in their homeroom could identify them easier. The peer educators also need to store their presentation materials and other supplies in one place that can be accessed by everyone. Some teachers felt that the peer educators should have their own room to make the program more accessible. Most importantly, the students wanted to know that their professionalism efforts were appreciated and rewarded through continued ownership and input.

At the time of the evaluation focus group, the peer educators from School 20 were more frustrated and had low morale over a lack of ownership. Unfortunately, the School

20 peer educators believe that their program has been added to the existing Red Cross program that uses students to promote good hygiene. From the onset, the Red Cross teacher wanted to get involved in the peer education program but the research team discouraged it as perceptions of that program could have affected the initiation and participation of the peer education program. The school doctor wanted the students involved in the Red Cross hygiene program to be trained as the peer educators. Although the research team has tried to keep these programs separate, the school administration has not treated the two different programs distinctly. Presently, peer educators share a room with the Red Cross program, which has a teacher co-ordinator that uses that room as well.

“We have done an introduction board on World AIDS Day but the Red Cross teacher tried to cheat us by saying that she had already done this board herself.”

“We want to be separate from the Red Cross people.”

“Sometimes we have difficulties because we don’t have own room to carry out our activities.”

This situation reinforces the importance of peer input and development of a program, otherwise the motivation to implement the program becomes less than the obstacles and discouragement the peer educators may face. As stakeholders, teachers and the program co-ordinator must keep peer educator ownership a priority for the program.

All stakeholders thought that the primary outcome of the peer education program would be improved sexual health knowledge among students in the participating schools because students will have easy access to accurate information. Not only the students in grades 8 and 9 who receive the program will have better knowledge, but also those students who receive the information second hand. HMIEC suggested that using questionnaires as pre-intervention and post-intervention tools may capture what students have learned. Also, these results could be compared to other study results. One student didn’t think that testing students was an effective measure.

“When you have a test, you just select one of the answers. Some students might copy from each other, ... there will be less opportunity to respond freely.”

Students’ behaviour may improve by taking better care of themselves and avoiding risky activity. HMIEC staff suggested that the pregnancy and STD infection

rates may decrease and therefore, screening should be done so this effect can be quantified. Attitudes may also improve, as the peer educators will act as ‘advisors’ for other students. One HMIEC staff participant suggested this:

“Attitudes will be changed, like a girl not being shy in front of a boy. Also, not be embarrassed to ask questions of teachers or parents.”

Screening for STDs and pregnancy are impractical outcomes and will continue to stigmatize students. However, as the socio-cultural aspects of sexual health reveal, embarrassment is a major barrier to communicating about sex, obtaining sexual health information, and seeking treatment. Evaluating a reduction in embarrassment may be an excellent outcome and indicator of the program’s progress.

MacPhail and Campbell (1999) reviewed many HIV interventions and found that evaluations that strictly concentrate on an individual level of analysis (knowledge, attitudes, and behaviours) fail to recognize the socio-cultural context of the intervention. The advantage of peer education is that it uses social relationships and interactions and should be situated in a supportive, health promoting community. Therefore, evaluations of peer education programs need to also explain the deeper collective processes that are at work. Furthermore, while quantitative research measure methods short-term results, qualitative methods are better at understanding the processes by which programs achieve these outcomes and learn how to make these programs sustainable over time. As such, both methods should be used and a commitment to process evaluation strategies is needed.

It was in this spirit of collectivism that the peer educators suggested that by observation, one could determine if their classmates knowledge, attitudes, and behaviour have changed. Also, student competitions among grades 8 and 9 could be organized to see which classes learned the most from the peer educators.

Support from a variety of agencies was not discussed in the focus groups as many community agencies became involved in the research and implementation of the peer education program, which already provided a strong sense of support.

CHAPTER 7

Conclusion & Recommendations

Introduction

This study provided a first time description of the socio-cultural aspects of sexual health among young people in Ulaanbaatar, Mongolia. By doing so, it becomes apparent that the challenges and struggles of young people in Mongolia are related to others in developed and developing countries. However, Mongolia is an extraordinary place, and the circumstances that shroud Mongolia also make the challenges that young people face heightened and more extreme. The framework of reciprocal determinism is used to explain similarities and differences between these socio-cultural aspects. The findings of this study confirm that peer education is a culturally appropriate intervention and that the multi-level support for such a program exists. Furthermore, by understanding the socio-cultural context, a peer education program can be tailored to suit its environment and therefore be made more successful and sustainable. General recommendations about the program design and direction are made and future research directions are discussed.

Findings Related to Reciprocal Determinism

This focus group study has highlighted a range of individual, behavioural, and socio-cultural determinants of sexual health among youth in Mongolia, recognizing that sexual health is determined by more than just knowledge, which does not necessarily translate into behaviour. Understanding that sexuality is negotiated in socio-cultural contexts, one must assess those environmental factors to facilitate the translation of knowledge into new behaviour. The concept of reciprocal determinism in social learning theory provides an appropriate framework in which to understand this interaction. Turner and Shepard (1999) have argued that peer education is in search of a theory. Much of the peer education literature limits social learning theory to its concepts about reinforcement and modelling for modes of education, neglecting the idea that these concepts work within the framework of reciprocal determinism where context, behaviour, and cognitive processes all interact to determine behaviour (Turner & Shepard, 1999; UNAIDS, 1997;

Melburn, 1995). Reciprocal determinism provides a good framework for peer educators and participatory research to frame their efforts. To demonstrate the efficacy of reciprocal determinism, the results of the focus groups are presented in the reciprocal determinism framework.

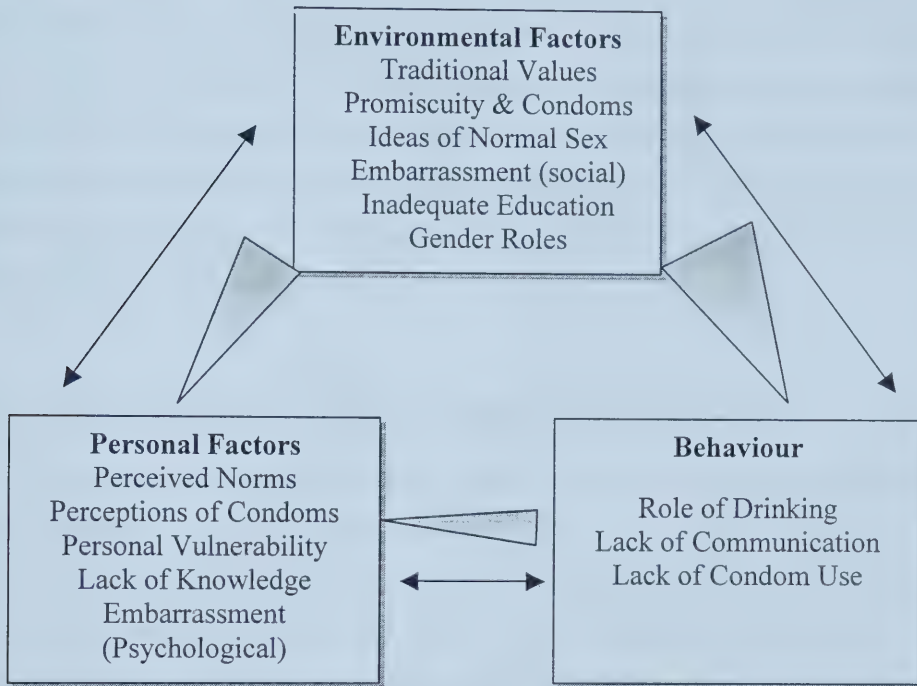


Figure 7.1 Factors influencing sexual health in Mongolian youth

By looking at the framework of results taken from the focus groups, it becomes clear that all these determinants of sexual health are interrelated and have the potential to affect one another. As mentioned in the findings, embarrassment about sexual matters does limit young people's communication about sex with adults. Inadequate education limits people's knowledge about sexual health and their ability to talk about it among their peers and across generations. Cultural notions that condoms are symbols of promiscuity will give negative connotations of condoms and reduce their use. Drinking may help girls manage their conflict between perceived norms of peer sexual behaviour and the need to keep a clean reputation to fulfill gender roles. Lack of communication about sex may fuel the misperceptions of sexual activity among young people.

Bandura (1977) argues that one's behaviour and personal factors are able to impact and change one's environment by bringing new people and role models into an individual's life. When considering some of these socio-cultural factors, it is not possible for one person to change a limited sexual health curriculum at their school or the conceptions of reputation and masculinity within Mongolia. However, if one looks at the framework of reciprocal determinism at a community level, which most health promotion interventions and participatory research programs are beginning to do, then it is possible to change the environment. A school of 3,000 young people who have changed the normative perception of sexual activity (i.e., personal factor) or communicate openly about sexual matters (i.e., behavioural factor) may be able to change the fluid concepts of traditional values and gender roles.

Comparison of Socio-cultural Aspects of Sexual Health Internationally

The focus groups provided a first time description about sexual health among youth in Mongolia, although the extracted themes do not present any new concepts about sexuality and health. The traditional values of the Mongolian patriarchal culture influence many of the aspects of sexual health, including embarrassment, cross generation communication, lack of knowledge, concepts of promiscuity, gender roles, and peer norms. These results are consistent with the studies that describe the contextual aspects of sexual health conducted in developing countries, perhaps illustrating that traditional values in patriarchal societies share many common elements. Many of the socio-cultural aspects of cultural health revealed in this study, such as gender imbalances, one's sexual reputation, difficulty speaking about sex with adults, male dislike for condoms, the connection between alcohol and sex, and believing that school curriculums are inadequate, can be identified with youth around the world. Indeed, these specific results may be generalized to the rest of Mongolia and perhaps to other developing countries as well because of its agreement with existing literature from other locales.

Despite the similarities, the magnitude of the influence that the environmental factors had on sexual health behaviour uncovered in this study seem to be greater than those in developed countries. This phenomenon can be explained by *Figure 7.1*. The

original reciprocal determinism diagram had equally sized, two-way arrows that theoretically depict a balance between the three factors. However, the findings from the focus groups indicate that the environmental factors (which include socio-cultural factors) in Mongolia are much stronger and disrupt the balance between the personal and behavioural factors, as is indicated by the large arrows directed from the environmental factors, and thereby dominating behaviour outcomes.

Mongolia has remained a very isolated country for most of the twentieth century with very little information from Western countries where sexual revolutions have taken place. Isolation has meant Mongolians remained close to the traditional values so that the socio-cultural aspects of sexual health may have a greater effect on sexual behaviour. For example, all adolescents are provided very little information from their teachers or family about menstruation, let alone about safer sex. Condoms carry heavy symbols of promiscuity, even among health staff. Those cultures that strictly adhere to gender roles are more susceptible to STD and HIV infections. Strong masculine roles encourage men to have multiple partners, initiate intercourse, and have unprotected sex. Also, male student discussions indicated that coercive sex is socially acceptable. Strong female roles stress the value of a clean reputation for girls with very strong sanctions to keep girls virgins as they have routine pelvic exams to determine virginity. In addition to traditional values, the social acceptance of very heavy drinking among men and the influx of Western media that has relatively high sexual content may contribute to unsafe sexual behaviour among Mongolian youth.

The media that comes from Western countries is quite open, something that these countries have grown into over the forty years since the sexual revolution. In fact, the sexual revolution was an internally motivated phenomenon that North Americans and Europeans were ready for. Mongolia, too, is on the verge of a sexual revolution, imposed, in part, by the influx of sexually explicit media (other factors include a very young population, and the increased presence of modern contraceptives). However, the thrust of this revolution comes from outside Mongolia: the values and decision making skills of the general population do not necessarily support it, creating very confusing times for young people who feel the pressure to be modern but also honour traditional values and parental expectations.

Perhaps the most striking sexual health risk in Mongolia is the excessive amount that people drink, at least in Ulaanbaatar. Although drinking vodka is a culturally accepted practice, hardships and a (apparently) recent emergence of bars and discos, have really increased the amount of drinking in the capital city. People drink to get drunk. The focus groups reveal that drinking is common among girls and that alcohol is the primary way boys are able to coerce girls into sex. Getting drunk and then having sex poses a major risk to STDs, unwanted pregnancy, and rape, as people are not able to defend themselves, negotiate safer sex, or properly use a condom (Crael et al., 1995). The focus groups indicated that drinking and party situations are the primary time place where students will have sex.

Implications for Peer Education in Mongolia

Peer Education is Appropriate

The results of the focus groups indicate that a school-based peer education program does have an important role to play in urban Mongolia because of some of the existing socio-cultural factors. The peer education program needs to educate students that are eager to learn sexual health information and provide students with culturally appropriate risk reduction skills including sexual decision making skills.

The focus group discussions identified knowledge as one of the major barriers to safer sex practices. The prevailing traditional values in Mongolia has disregarded sexual health education as a priority within the educational system resulting in teachers not being formally trained on the topic, limited lesson hours, and an ad hoc application of the existing curriculum. In addition to the education system, the generation gap between adults (parents and teachers) and youth is isolating young people and eliminating a source (albeit limited) for sexual health information. Finally, with the recent political changes has come the influx of Western media into Mongolia, providing Mongolia with more sexual information (although perhaps not accurate).

In this context, peer education is appropriate. First, a school-based peer education program can supplement a weak formal education system and tackle those relevant sexual

issues that teachers are not comfortable addressing such as condom demonstrations and relationship activities, while providing another forum for questions to be answered that were generated in class. It is not meant to replace the formal lessons that teachers provide. Second, peer education is able to circumvent the communication barriers between teacher and student or parent and child by providing reliable information through peers, an existing primary source of information. Third, peer education can do what teachers and parents are not equipped to do themselves: critically assess information available in the media.

Limitations of Peer Education in Mongolia

Upon considering the magnitude of socio-cultural factors that affect sexual health, realistic expectations of a peer education program must be set. A school-based peer education program cannot reduce unwanted pregnancy and sexually transmitted infection rates on its own. It must be simultaneously supported by a ‘health promoting community’ that attempts to breakdown socio-cultural barriers such as socially subscribed gender norms, provides better sexual health information to adolescents and parents, and provides teen friendly health services. Nonetheless, interventions that work at a community level in an attempt to educate and address some of the social processes that influence behaviour are still needed. This study has also provided insight into how a peer education program may be able to educate and build skills that can work between socio-cultural factors to improve young people’s lives. Such an intervention is a capacity building exercise for a community, and hopefully with time and persistence, this intervention may give way to policy and service changes that may have a greater impact among youth.

Program Directions & Design

Peer education needs to allow students to “renegotiate their sexual and social lives at the collective level” as sexual behaviour change is more likely to occur through the influence of peers than through the rational choices made by individuals (MacPhail & Campbell, 1999, p. 153). As a group, students and peer educators can negotiate

acceptable, safer sex behaviour through focus groups or seminar-style events within the schools. Focus groups proved to be very productive for the peer educators and provided an opportunity for peer development. By listening to their suggestions and providing training, the peer educators began to see positive changes with their social networks at school, with teachers, and even parents. Peer (and student) development needs to be a priority of the program. Group negotiation is also an excellent way for the students to develop critical thinking skills around messages in the media and gender roles.

To the researcher's knowledge, there are no interventions in Mongolia that address drinking among young people, let alone the relationship drinking has with sex. Peer education cannot stop the social pressure of drinking to get drunk, especially among boys and men. However, peer education can play a vital role of providing essential survival skills that may be perceived as authoritative from any other source. Peer education needs to provide the clear message that sexual decisions need to be made when one is sober. Those decisions need to be discussed with close same-sex friends that will help each other protect that decision. When youth do drink, one friend needs to stay sober to make sure their drinking friends act according to their sexual decisions, ensure that every one gets home safely, and be ready to perform precautionary measures if someone has consumed too much alcohol. By enforcing sexual decisions, students increase their self-confidence that will spread to other aspects of health in their lives (University Health Centre, 2000). The researcher discussed this with the peer educators (in a limited manner between translation and time) at the peer educator training session. They were clearly shocked as they had never heard information like that before and were vocally thankful for that discussion. This single issue could really define the program and present some unique and very relevant, measurable outcomes.

The peer education program must incorporate the concept of social norming into its lessons to reinforce that most of their peers are not sexually active. Doing so would deflate some of the perceived norms of sexual activity that have become inflated through gossip, indirect talk, and reputations. This would decrease the pressure to have sex. Also, making teachers aware that more students are having sex than they think may motivate teachers and school administrations to make the sexual health curriculum and the efforts of the peer educators a greater priority within the school agenda.

Teachers and parents also have an important role in sexual health education and the peer education program could provide the means for their participation. For example, they could help the students assess media messages. To accomplish this, the peer education program may have to conduct educational workshops for the teachers and parents a couple of times a year to increase their knowledge level and help understand the students' situation.

The consultation and evaluation focus groups with all the stakeholders revealed some important details about the peer education program design that are listed below.

- The co-ordinator must be a health professional that could liaise between school administration and the peer educators. The co-ordinator and HMIEC should support the peer educators by officially recognizing the training (by certificate) and by providing regular contact and periodic training sessions.
- The full support of all school staff is needed for the program and the peer educators to be successful. Introducing the objectives of the program and the peer educators to the whole teaching staff can encourage this support. School support includes identification of the most optimal time for the peer educators to present to classmates.
- The peer educators should be selected for their leadership, open-mindedness, and good communications skills.
- The peer educators should be trained by health professionals (not teachers) in interactive ways with support material.
- Peer educator training should address STDs, contraception, anatomy, hygiene, and friendship in a co-ed environment.
- Peer educators should work in teams to support each other, help manage the class, and provide internal feedback.
- The peer educators must feel that they have significant ownership of the program, including input, feedback, and operation.
- Each program in each school must have a visual identity that can be recognized by peers and teachers.

The suggestions that the stakeholders made regarding outcomes and evaluation tools were generally very standard and focused on the increase in knowledge and a reduction in pregnancy and sexually transmitted infections. Rather, the socio-cultural context illuminated realistic and novel ways of evaluating peer education programs beyond the frequently used knowledge, attitudes, and behaviour approach that neglect the environment in which sex is negotiated. Indicators like reduction in embarrassment, changes in communication (words use, circle of friends), perceptions of gender norms, and delayed first sex might be more useful indicators as they may be more descriptive and may be more closely related to behaviour change. MacPhail and Campbell (1999) suggest that qualitative and quantitative methods should be used together with process evaluation in mind. The students suggested evaluations that involved group contests or observation, which are appropriate for an intervention that aims to address collectively negotiated norms, perceptions, and behaviours.

Furthermore, the program and the participating schools should also consider how it could evaluate some of the secondary effects of the peer education program. For example, some of the students mentioned how they began to educate their neighbours, communicate better with parents, and participate more in school. These effects are real outcomes of the program that need to be captured. They will provide constructive feedback to the program on its influence on the environmental context and provide new indications for new community-based health-promoting interventions, such as workshops for parents and teachers.

Limitations

The primary limitation of this study was that saturation of the themes might not have been achieved due to the study design, time, and resource constraints. Although the data collected in this study provides a broad range of opinions and issues regarding sexual health, the researcher cannot guarantee that all of these opinions and issues may have been exhausted.

The thrust of the present study was to explore and describe the culture of sexual health among youth in Mongolia with the intention of implementing a school based peer

education program. Therefore, the purpose of the focus groups was to ask the stakeholders their opinions about communication, language, dating activities, knowledge, and attitudes towards the school curriculum. Structured focus groups were used to manage language barriers and touch on many different issues about sexual health. By doing so, the data collected represents a broad array of socio-cultural aspects of sexual health, and even some personal factors such as perceived norms and vulnerabilities. Unstructured focus groups may have allowed participants to explore topics that are of concern to them in more detail. Furthermore, each one of the socio-cultural aspects of sexual health elucidated in this study could be studied independently in much more detail on their own in future studies.

Not all the data from this study can be generalized about young people throughout Mongolia. For example, while it can be generalized that most students will have difficulty discussing sexual matters with adults, it may be more difficult for different reasons for rural students. Likewise, rural students will not have as much exposure to Western media as students living in Ulaanbaatar. To determine transferability, researchers within Mongolia must assess this study's design (i.e., the age group, how the participants were selected, and urban locale) to determine if these findings may be transferable to other situations within the country.

Further Research in Mongolia

Immediate research that should be conducted that could affect the content of the peer education program are (a) what behaviours make some students resistant to the socio-cultural norms and (b) prevalence and descriptive studies about alcohol use among young people.

Rivers and Aggleton (1999) assert that adolescents are not a homogenous population. Indeed, the researcher found some variability among the research participants with regard to sexual attitudes and personal struggles. MacPhail and Campbell (2001) suggest studying young people who are resilient to, and challenge, harmful social and cultural norms to gain important insight into the development of new, socially appropriate behaviour that could be used to set new norms in the peer group. In Mongolia, qualitative

research could be used to study boys that have positive attitudes towards condoms or girls that are not very concerned with maintaining the reputation to adhere to gender norms to apply those healthy behaviours in a peer education setting.

To the researcher's knowledge, there have been no studies in Mongolia that have studied the prevalence of drinking among youth and the health risks that are taken while drunk. A quantitative study should be conducted in both rural and urban locations to determine differences in behaviour. Also, gender differences should be explored. Results of such a study might help promote healthy drinking behaviour among youth by clarifying what normative drinking behaviour really is. Also, any research on this topic would bring attention to the serious drinking problem that appears to exist in Mongolia.

Focus groups should also be conducted among boys and girls to explore the relationship between drinking and sex. Understanding this relationship is very pertinent to the efforts of the existing peer education programs in Schools 20 and 58 and could improve upon the recommendations made in this study.

International Implications

This qualitative study provides a first time description of the socio-cultural factors that influence sexual health among young people in Ulaanbaatar, Mongolia. It also adds to the limited amount of information available in the literature about the complex scope of sexual health among young people in developing countries (MacPhail & Campbell, 2004). The use of the reciprocal determinism framework to explain the results of this study may be useful for other peer education programs around the world to help understand the interaction of socio-cultural aspects of health with behavioural and personal factors. In doing so, community based interventions are better able to assess their objectives and evaluation tools.

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APPENDIX 1.1

Map Of Mongolia



APPENDIX 2

Information Sheets

Appendix 2.1

INFORMATION SHEET - HMIEC Staff Peer-led sexual health education program for adolescence to reduce STIs

Hello,

My name is Amanda Roberts. I am a graduate student from the University of Alberta in Canada. I have been invited by HMIEC in Ulaanbataar to find how teens could teach teens information about sexual health for my thesis project. We would like to start a 'Peer Educators' program that teaches classmates in class and at break topics they want and need to know about sex. This program will complement the sexual health courses at school.

Procedure: We want to develop a peer education program deals with sexual issues that students really want to know about. To do this we I am meeting with HMIEC staff, teachers, and selected peer educators to get ideas. A group of eight HMIEC staff will be interviewed for about 2 hours. We will ask your group questions on the following topics:

- what information you would like to be included in the peer education program
- how you think a peer education group would work best in your school
- what outcomes you would like to see as a result of the program

Your answers will be audio taped. After we meet with peer educators, they will be well trained on many sexual health topics. They will also make a presentation that they will present in class and at break. A questionnaire that was made based on your ideas about outcomes will be given to all the students who saw the presentations.

Benefits: The ideas from these meetings will be used to make a peer education program that is more useful for the students. Your ideas about content will help decide what information will be used to train the peer educators and make class presentations with. The outcomes that you want to see will be built into the questionnaire. Having good outcomes makes the program more sustainable.

Risks: There is a chance that someone from your group meeting could break the rules and tell the staff some of your answers.

Confidentiality: To make sure no one tells anyone the answers you gave at the group meetings, your group will have to agree on some meeting rules. These meeting rules include:

1. Not repeating what was said in the interview
2. You have the right not to answer any questions that make you feel uncomfortable

The final report of this study that will be given to the Peer Educators and HMIEC will use only major ideas; no names or direct comments from the group meetings will be written. Your answers that are recorded on audiotape will be written into English. All the data will be kept for at least 7 years in a safe place at the University of Alberta, Canada. Only the research team will know where the data are.

You do not have to be a part of the study and can withdraw at any time without any problems.

*Please contact HMIEC's secretary, Narantuya Sunduijav,
at 976-1-32-10-93 if you have any questions or concerns.*

Appendix 2.2

INFORMATION SHEET - Teachers Peer-led sexual health education program for adolescence to reduce STIs

Hello,

My name is Amanda Roberts. I am a graduate student from the University of Alberta in Canada. I am working with the health experts at HMIEC in Ulaanbataar to find how teens could teach teens information about sexual health for my thesis project. We would like to start a 'Peer Educators' program that teaches classmates in class and at break topics they want and need to know about sex. This program will complement the sexual health courses at school.

Procedure: We want to make a peer education program deals with sexual issues that students really want to know about. So, we are meeting with HMIEC staff, teachers, and selected peer educators to get ideas. A group of eight peer teachers from two schools will be interviewed for about 2 hours. We will ask your group the following questions:

- what information you would like to be included in the peer education program
 - how you would like to work with the peer educators
 - how you think a peer education group would work best in your school
- Your answers will be audio taped. After we meet with peer educators, they will be well trained on many sexual health topics. They will also make a presentation that they will present in class and at break. All the students that saw the peer educators will fill out a questionnaire. This will tell us how they presentation, how valuable it was to them, and how much they learned.

Benefits: The ideas from these meetings will be used to make a peer education program that is more useful for your students. Your ideas about content will help decide what information will be used to train the peer educators and make class presentations with.

Risks: There is a chance that someone from your group meeting could break the rules and tell the school-staff some of your answers.

Confidentiality: To make sure no one tells anyone the answers you gave at the group meetings, your group will have to agree on some meeting rules. These meeting rules include:

3. Not repeating what was said in the interview
4. You have the right not to answer any questions that make you feel uncomfortable
5. Only my supervisor in Canada and I will have access to the information that the students and teachers provide. Only grouped, anonymous data will be shared with HMIEC.

All data will be kept in a safe place for at least 7 years at the University of Alberta in Canada.

Only the research team will know where the data are.

You do not have to be a part of the study and can withdraw at any time without any problems.

*Please contact HMIEC's secretary, Narantuya Sunduijav,
at 976-1-32-10-93 if you have any questions or concerns.*

Appendix 2.3

INFORMATION SHEET – School Principal Peer-led sexual health education program for adolescence to reduce STIs

Hello,

My name is Amanda Roberts. I am a graduate student from the University of Alberta in Canada. I am working with the health experts at HMIEC in Ulaanbataar to find how teens could teach teens information about sexual health for my thesis project. We would like to start a 'Peer Educators' program that teaches classmates in class and at break topics they want and need to know about sex. This program will complement the sexual health courses at school.

Procedure: We want to make a peer education program deals with sexual issues that students really want to know about. So, we are meeting with HMIEC staff, teachers, and selected peer educators to get ideas. A group of eight students from your school will be interviewed for about 2 hours on three different days. We will ask the students group the following questions:

- what information you would like to be included in the peer education program
- how you would like to work with the peer educators
- how you think a peer education group would work best in your school

Their answers will be audio taped. After we meet with students, they will be well trained on many sexual health topics. They will also make a presentation that they will present in class and at break. All the students that saw the peer educators will fill out a questionnaire. This will tell us how they presentation, how valuable it was to them, and how much they learned.

Benefits: The ideas from these meetings will be used to make a peer education program that is more useful for your students. Student input will help decide what information will be used to train the peer educators and make class presentations with.

Risks: There is a chance that someone in the focus group meeting could break the rules and tell the classmates some of their answers.

Confidentiality: To make sure no one tells anyone the answers the students gave at the group meetings, each group will have to agree on some meeting rules. These meeting rules include:

6. Not repeating what was said in the interview
7. You have the right not to answer any questions that make you feel uncomfortable
8. Only my supervisor in Canada and I will have access to the information that the students and teachers provide. Only grouped, anonymous data will be shared with HMIEC.

All data will be kept in a safe place for at least 7 years at the University of Alberta in Canada.

Only the research team will know where the data are.

Your students do not have to be a part of the study and can withdraw at any time without any problems.

*Please contact HMIEC's secretary, Narantuya Sunduijav,
at 976-1-32-10-93 if you have any questions or concerns.*

Appendix 2.4

INFORMATION SHEET – Student Peer-led sexual health education program for adolescents to reduce STIs

Dear Student,

Hello, my name is Amanda Roberts. I am a graduate student from the University of Alberta in Canada. I am working with health experts at HMIEC in Ulaanbataar to find out from you how teens could teach teens information about sexual health for my thesis topic. We would like to train a group of students to become peer educators. The peer educators will teach their classmates topics that they need to know about sex and sexually transmitted infections in classes and at break. This new program will be a complement to the sexual health classes taught by teachers.

To be apply to be a peer educator we need the following:

1. Briefly tell us why you want to be a peer educator in 3 minutes (Dr. Oyun will come to your school to meet you).
2. We need you to read this information sheet and sign the consent form.

We will select students based on class diversity (people with different talents and interest in school) and level of interest in the peer education program.

How it works: We are using research to implement and evaluate a pilot peer education program. The most important part of this program is the peer educators. That is why there are many parts of this project that the peer educators must be a part of. Being a peer educator is a big job and it will require a lot of time. Here is what the peer educators have to do:

- 1) To make sure that this peer education program deals with sexual issues that students really want to know about, we want to interview the peer educators two times for about 2 hours after school. Girls and boys will not be interviewed together. We want to ask your group questions about your sexual knowledge and what topics you want to learn about. We also want to know how you learn the best. Your answers will be audio taped.
- 2) The health experts from HMIEC will train the selected students to become peer educators. This will take two weekends. You need to learn lots of information so that you can answer questions from the other students.
- 3) The peer educators will meet with me to design presentations that will be given in their schools. This might take a few meetings after school to complete. Then you need to practice the presentations.
- 4) You will teach the presentations to their classmates.
- 5) You will be interviewed one more time after school to tell me what you learned as well as what you liked and did not like about the program.

Good points:

- 1) The ideas from the interviews will be used to make a peer education program that can make teens healthier.
- 2) You will learn a lot about sexual health and will become a better public speaker.
- 3) Other new skills will be developed.

- 4) It can be a lot of fun.
- 5) You will receive a certificate stating that you finished peer educator training.

Possible Risks: There is a chance that someone in the group interviews may break the rules and tell someone your answers.

For your privacy: To make sure no one tells anyone the answers you give at the interviews, there will be group interview rules. These include:

1. No repeating what was said in the interview.
 2. You have the right not to answer any questions that you do not want to answer.
 3. Only my supervisor in Canada and I will have access to the information that the students and teachers provide. Only grouped, anonymous data will be shared with HMIIEC.
- All data will be kept in a safe place for at least 7 years at the University of Alberta in Canada. Only the research team will know where the data are.

You do not have to be a part of this study and can withdraw from the program at any time without any problems.

Please contact HMIIEC's secretary, Narantuya Sunduijav, if you have any questions or concerns about the peer education program or this study.

Enkhtaiban str. 13b
Ulanbataar – 210648
976-1-32-10-93

APPENDIX 3

Consent Forms

Appendix 3.1

<p style="text-align: center;">CONSENT FORM – HMIEC Staff Peer-led sexual health education program for adolescents to reduce STIs</p>

Principal Investigator:
Amanda Roberts
Public Health Sciences
University of Alberta, Canada

Co-Investigator: Dr. Oyun
Health Information Management and Education
Centre
Enkh-tiban str. 13b
Ulaanbataar – 210648, 329-429

Please answer the following questions by circling yes or no.

Do you understand that you will be participating in a research study that will help to develop a peer education program?	Yes	No
Have you read a copy of the attached Information Sheet?	Yes	No
Do you understand the benefits and risks that you may experience By taking part in this research study?	Yes	No
Have you had an opportunity to ask questions and discuss this study?	Yes	No
Do you understand that you are free to withdraw from this study at anytime for any reason without any problems?	Yes	No
Has the issue of confidentiality been explained to you?	Yes	No
Do you understand who will have access to the data?	Yes	No

Participant

I agree to take part in this research study.

Printed name of participant

Signature of participant

Date

Witness

I believe that the person signing this form understands what is involved in the study and voluntarily consents to participate.

Signature of Investigator or Designee

Date

Appendix 3.2

CONSENT FORM – Teachers Peer-led sexual health education program for adolescents to reduce STIs

Principal Investigator(s):

Amanda Roberts
Public Health Sciences
University of Alberta, Canada

Co-Investigator(s): Dr. Oyun

Health Information Management and Education
Centre
Enkhtiban str. 13b
Ulaanbataar – 210648, 329-429

Please answer the following questions by circling yes or no.

Do you understand that you will be participating in a research study that will help to develop a peer education program?	Yes	No
Have you read a copy of the attached Information Sheet?	Yes	No
Do you understand the benefits and risks that you may experience By taking part in this research study?	Yes	No
Have you had an opportunity to ask questions and discuss this study?	Yes	No
Do you understand that you are free to withdraw from this study at anytime for any reason without any problems?	Yes	No
Has the issue of confidentiality been explained to you?	Yes	No
Do you understand who will have access to the data?	Yes	No

Teacher

I agree to take part in this research study.

Printed name of teacher

Signature of teacher

Date

Witness

I believe that the person signing this form understands what is involved in the study and voluntarily consents to participate.

Signature of Investigator or Designee

Date

Appendix 3.3

CONSENT FORM – Principal Peer-led sexual health education program for adolescents to reduce STIs

Principal Investigator:

Amanda Roberts
Public Health Sciences
University of Alberta, Canada

Co-Investigator: Dr. Oyun

Health Information Management and Education
Centre
Enkh-tiban str. 13b
Ulaanbataar – 210648, 329-429

Please answer the following questions by circling yes or no.

Do you understand that some of your students will be participating in a research study that will help to develop a peer education program?	Yes	No
Do you understand that selected classes will see the peer educator presentations and will fill out a questionnaire to provide feedback?	Yes	No
Have you read a copy of the attached Information Sheet?	Yes	No
Do you understand the benefits and risks that your students may experience by taking part in this research study?	Yes	No
Have you had an opportunity to ask questions and discuss this study?	Yes	No
Do you understand that your students are free to withdraw from this study at anytime for any reason without any problems?	Yes	No
Has the issue of confidentiality been explained to you?	Yes	No
Do you understand who will have access to the data?	Yes	No

Principal

I agree to allow selected students take part in this research study and the peer education program.

_____	_____	_____
Printed name of principal	Signature of principal	Date

Witness

I believe that the person signing this form understands what is involved in the study and voluntarily consents to the participation of his / her students.

_____	_____
Signature of Investigator or Designee	Date

Appendix 3.4

CONSENT FORM – Students Peer-led sexual health education program for adolescents to reduce STIs
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Principal Investigator(s):
Amanda Roberts
Public Health Sciences
University of Alberta, Canada

Co-Investigator(s): Dr. Oyun
Health Information Management and Education
Centre
Enkh-tiban str. 13b
Ulaanbataar – 210648, 329-429

Please answer the following questions by circling yes or no.

Do you understand that you will be participating in a research study that will help to develop a peer education program?	Yes	No
Have you read a copy of the attached Information Sheet?	Yes	No
Do you understand the benefits and risks that you may experience by taking part in this research study?	Yes	No
Have you had an opportunity to ask questions and discuss this study?	Yes	No
Do you understand that you are free to withdraw from this study at anytime for any reason without any problems?	Yes	No
Has the issue of confidentiality been explained to you?	Yes	No
Do you understand who will have access to the data?	Yes	No

Student

I agree to take part in this research study and the peer education program.

Printed name of student

Signature of student

Date

Witness

I believe that the person signing this form understands what is involved in the study and voluntarily consents to participate.

Signature of Investigator or Designee

Date

Appendix 3.5

CONFIDENTIALITY FORM

Peer-led sexual health education program for adolescents to reduce STIs

Principal Investigator(s):

Amanda Roberts
Public Health Sciences
University of Alberta, Canada

Co-Investigator(s): Dr. Oyun

Health Information Management and Education
Centre
Enkhriban str. 13b
Ulaanbataar – 210648, 329-429

All the qualitative data collected in the 'Peer-led sexual health education program' are sensitive information because they are attached to the experiences of the people that gave the data to us. For this reason, it is important for you to sign this confidentiality form as a term of your employment. That means that any data that you gather, transcribe, or translate cannot be repeated to anyone but Amanda Roberts and Dr. Oyun at any time during or after this study. All written and audio taped data will be kept in a safe place with Dr. Laing at the University of Alberta for at least 7 years.

I agree not to repeat any of the data that I may be working with to anyone but the primary and co-investigators as a term of my employment.

Printed name

Signature

Date

Witness

I believe that the person signing this form understands the terms of this confidentiality agreement.

Signature of Investigator or Designee

Date

APPENDIX 4

QUESTION GUIDES

Please note that all these questions guides are a first draft that were translated into Mongolian. This draft does not include the revisions that were used in the actual focus groups.

Focus Group Interview Guide

Welcome the participants and thank them for coming.

Introductions

- Introduce yourself as the moderator and share some background experiences. Introduce the observer and the translator with their backgrounds.
- Have participants introduce themselves, their position at work, and say something personal about themselves (e.g. their favourite thing about autumn).

Explain the roles of the research team

- Moderator = Help directs the discussion of the group to ensure that the objectives of the focus group discussion are met.
- Observer = Operates the tape recorder and takes extra notes on the discussion. The observer may need to pass a message to the moderator during the discussion.
- Translator = Briefly translates the focus group discussion to the observer since she does not speak English.

State the study objectives of the project (listed below).

The opinions of the HMIEC staff are important to the peer education program because HMIEC is the institution through which it will be operated. The program must be designed and evaluated in such a way that it can contribute to HMIEC reports and its funding can be justified. Therefore, the goal of this focus group is to determine what information should be included in the peer education program and how this program can be sustained for two years.

This focus group discussion will last 2 hours.

Explain that all answers will be audio taped so that we can remember what was said. What is said here is confidential. The focus group audio tapes and translations will be kept in Canada. Only themes and ideas from the focus groups, not direct comments will be presented in the final report.

Explain that we use ground rules to make everyone feel safe, ensure that their comments are confidential, and to make the discussion go smoothly. Reviews ground rules (written on the white board) and encourage participants to add new ground rules they think are necessary.

- 1) Right to pass (not answer a question)
- 2) Respect others' opinions
- 3) Right to be heard (only one speaker at a time)
- 4) Agree to disagree in the discussion
- 5) Respect confidentiality of personal information (do not discuss it outside this room).
- 6) There is no such thing as a stupid question.

Turn on the tape recorder.

Proceed to ask questions without using participant names. *Remember that the question guides are just guides, keep the focus group and project objectives in mind!*

At the end of the two hours, review the main points of the discussion to recap and clarify what was discussed. Turn off the tape recorder.

Thank the participants for coming and that the moderator will pay them for their participation.

If time remains after all the questions are asked, allow some time for informal questions from the participants about the study or sexual health.

After the focus group discussion, the research team should debrief:

- Catch your breath!
- Reflect on how the focus group interview went (overall impressions) – discuss with fellow researchers;
- Acknowledge what went right and make note of it for next time;
- Acknowledge what went wrong and make note of how to improve it for the next time (this is a good time to work on improving probes and follow up questions, to be better prepared for the next interview or focus group);
- The moderator and observer should make final notes alone and meet at a later date to compare notes and review the interview once more to write a final report.

Study Objectives:

- 1) To find out what adolescents know about sexual health, what topics require more education, and what barriers exist to safer sexual practices.
- 2) To determine what information should be delivered through a peer-led sexual health education program, how the information should be delivered, and what measurable outcomes should be evaluated so that this program can be effectively educate youth and remain sustainable.
- 3) To enable youth to become effective educators of their own peers on matters related to sexual health
- 4) To develop a training manual, presentation outlines, and evaluation instruments that can be used in the future by the peer educator program and used as a reference for other initiatives.

Appendix 4.2

HMIEC Consultation Focus Group Interview

Attitudes & Perceptions

- 1) Do you think that the school sexual health curriculum is adequate?
- 2) What are the barriers for adolescents to adopt safer sexual practices?
 - a) Accessibility?
 - b) Attitudes?
- 3) Is peer education a realistic intervention?

Program Design

- 4) If given the appropriate training, would you trust the students to teach their peers accurate information? Why or why not?
- 5) How might you ensure the quality of the information peer educators provide?
- 6) What information do you think peer educators would be best suited to teach?
- 7) Should peer educators distribute condoms?
- 8) How would peer educators do this?
- 9) How should peer educators be rewarded for their work and professionalism?

Program Sustainability

- 10) A high quality peer education program would have a trained peer education co-ordinator that would have monthly meetings with the peer educators, provide periodic in-services, and compile presentation evaluations and reports. How might HMIEC keep a peer education program sustainable until June 2001?
 - a) Co-ordinator
 - b) Financially (taxi's, bus passes, office supplies)
 - c) Information resources
- 11) What outcomes of the peer educator program (over a one-year period) are needed to sustain the program for another year, including training new peer educators?
- 12) What questions should be asked on presentation evaluation forms?

Appendix 4.3

Teacher Consultation Focus Group Interview

Sexual Health Perceptions

- 1) How serious a problem do you think STDs/ HIV are in Mongolia? Ulaanbaatar?
- 2) In your opinion, how much sexual activity is going on among youth?
 - a) What kind of sexual activity is occurring?
- 3) What are the barriers to adopting safer sexual practices?
 - a) Accessibility?
 - b) Attitudes?
- 4) Is peer education a realistic intervention?

Program design

- 5) Do you think that the school sexual health curriculum is adequate?
- 6) How do you think a peer education program could improve the sexual health in your school?
- 7) If given the appropriate training, would you trust the students to teach their peers? Why or why not?
- 8) How might you ensure the quality of information that the peer educators are using?
- 9) What information do you think peer educators would be best suited to teach?
- 10) What information should not be taught by peer educators? Why?
- 11) How do you think a peer education program could work in your school?
- 12) Could peer educators present on sexual health in a class?
- 13) Do you think teachers should be present during presentations?
- 14) Do you think students could hold information sessions at noon break?
- 15) Do you think peer educators should distribute condoms? If so, how could they do this?
- 16) What outcomes from this program would make you want to keep the program at your school?
- 17) How should students be rewarded for their work & professionalism?

Appendix 4.4

Consultation Student Focus Group Discussion #1 (10/5/00) Males & Females

STDs and Contraception: Knowledge & Attitudes

- 1) How serious a problem do you think sexually transmitted diseases including HIV / AIDS is in Mongolia? In your school?
- 2) If a man and woman want to avoid pregnancy or contracting a sexually transmitted disease, what can they do? (Name all the methods you know about).
- 3) Which methods work the best for pregnancy? For STDs?
- 4) If you wanted information about sexual health or contraception, where would you go?
 - a) What are the good points about each source?
 - b) What are the bad points about each source?
- 5) What barriers exist to finding accurate sexual information, skills, and contraception?
 - a) Are there any barriers that only affect young people? Why?
- 6) What messages do you get from the media about sex?

Identification of Sexual Practices

- 7) What do boys and girls do together on a date?
- 8) What kinds of words do you use when you talk about sex?
- 9) What kind of sexual activities do boys and girls have? (hold hands, kissing, hugging, fondling, oral sex, vaginal intercourse, anal intercourse)
- 10) Are many of your peers trying sexual intercourse (vaginal or anal) for the first time?
- 11) Do most people use a condom on their first time?
- 12) Is it common for couples your age to have sexual intercourse?
- 13) Is it common for couples to use a form of contraceptive?
- 14) Do you think young people are more sexually active after they have been drinking?
 - a) Why do girls drink and then have sex?
 - b) Why do boys drink and then have sex?

Values Clarification

- 15) Gender roles are the different jobs society expects boys to do and girls to do. There are sexual roles as well. For example, a boy may be expected to pay for the girl when they go on a date. Also, boys are expected to want sex and girls are not.
 - a) Can you think of any other gender roles that affects how a relationship works?
 - b) Can you think of how gender roles might affect using condoms or deciding when to have sex?

- 16) If you were in a relationship, would you like your boyfriend / girlfriend to offer to use a condom? Why or why not?
- a) How easy or difficult would it be to bring up the idea of using a condom?
 - b) What are the common reasons for not using a condom?
- 17) What would happen if you (or your partner) got pregnant today?
- a) Do you think being pregnant could change plans for the future? How?
 - b) Do you think having a STD could change plans for the future? How?
 - c) Would you like to have children some day?

Appendix 4.5

Consultation Student Focus Group Discussion #2 (10/12/00) For Males & Females

Program Design

- 1) What is the worst thing about your sexual health classes at school?
- 2) What sexual topics are teachers good at teaching in class?
- 3) What information is not being taught in your school, or is being taught poorly, should be taught by the peer educators?
- 4) Why is this information important to young people?
- 5) Are there any topics that well trained peer educators are not capable of discussion?
- 6) Talking about sex can be embarrassing, but it is also important. What techniques can the peer educators use with their peers to make it easier to talk about?
- 7) Would it help for the formal presentations to your peers to be separated by sex for certain topics?
- 8) The peer education program needs an adult leader to coordinate meetings, compile evaluations, and make reports about the program. This person would be the one you went to if you had any questions or concerns about the program. Should this person be a teacher from your school or someone from HMIEC or another health agency? Is it okay for teachers to be involved?
- 9) Should teachers be allowed to watch your formal presentations?
- 10) Should peer educators distribute condoms in their school? How? When? At what price?
- 11) How would you know if the peer education program were effective or helpful to your peers?
- 12) How do you think you will benefit personally from being in the program?
- 13) How should the peer educators be rewarded for their work and professionalism?

Peer Educator Training

- 14) What topics about sex and sexuality would you like to learn the most at your training?
- 15) How do you and your peers like to learn? (Skits, pictures, role playing, lecture).
- 16) Who should be involved at training? Health experts? Teachers?
- 17) Are there any topics at training that should be separated by sex?
- 18) Training will take two days to complete and should occur on a weekend. What weekend in October would be good for you?

Appendix 4.6

<p>Evaluation Focus Group Discussion for Peer Educators School 20 & School 58</p>

Being a peer educator

1. What is the most fun about being a peer educator?
2. What is difficult about being a peer educator?
3. Do students tease you for talking about sex? Does this make you feel uncomfortable?
4. Has training provided you with sexual health information that you would not be able to get anywhere else? Give examples.
5. Has being a peer educator changes some of your attitudes about:
 - a. Sexual decision making
 - b. Your susceptibility to STDs
 - c. Using condoms
6. Has being a peer educator changed how you talk about sex with your friends or your behaviours within a relationship? How?
7. How might being involved in the peer education program affect your future?

Peer education in your school

8. Do you find it easy to talk about sexual health matters with your classmates?
9. Do teachers treat you differently? Do they support your work as a peer educator?
10. Do you feel that there is pressure on you to be a good example in your school?
11. Do your classmates really believe that they are at risk of getting an STD?
12. Does your classmates like your STD presentation and the question periods that you have provided to them?
13. Is the information relevant and interesting to them? Why?
14. Is the information presented in a fun way or do you find the students are bored?
15. Are they glad that there are students in their school that they can get reliable sex information from?
16. Do students feel comfortable enough to come up to you and ask sexual health questions in private?

The peer education program

17. What is the best thing about the peer education program?
18. What things in the program need improvement? How could these areas be improved?
19. Are there certain aspects of the peer education program that make you concerned for its future?
20. Is the support from HMIEC and your school administration sufficient?

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